JOURNAL

of the

AMERICAN PODIATRY ASSOCIATION

ANNUAL MEETING
WASHINGTON, D. C.
AUGUST 22-26, 1958

The Official Publication of the Podiatry-Chiropody Profession

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VOLUME 48, NUMBER 3 MARCH, 1958

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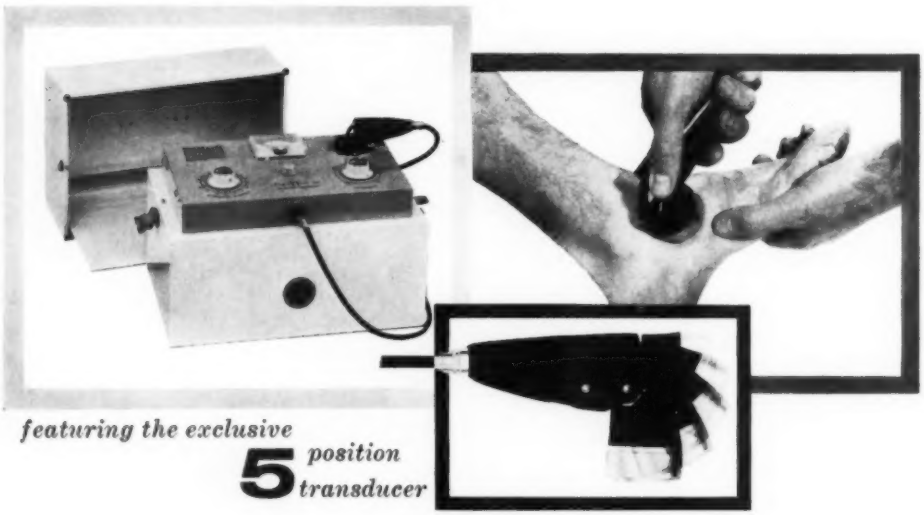

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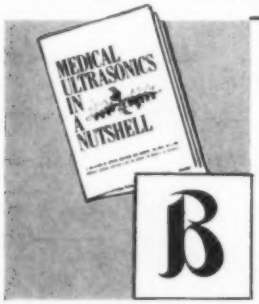

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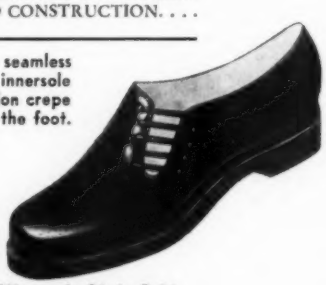

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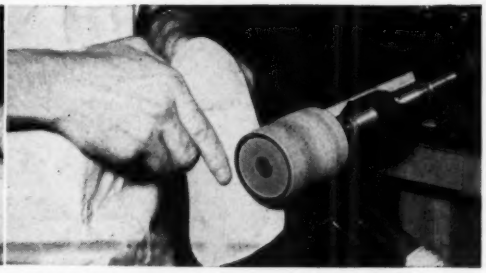

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The Idaho State Board of Chiropody-Podiatry will meet for reciprocity and examination on July 8-10, 1958, at the Capitol Bldg., Boise, Idaho. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

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The Illinois Chiropody Examining Committee. **Superintendent of Registration:** Frederic B. Seicke, Dept. of Registration and Education, Capitol Bldg., Springfield, Ill.

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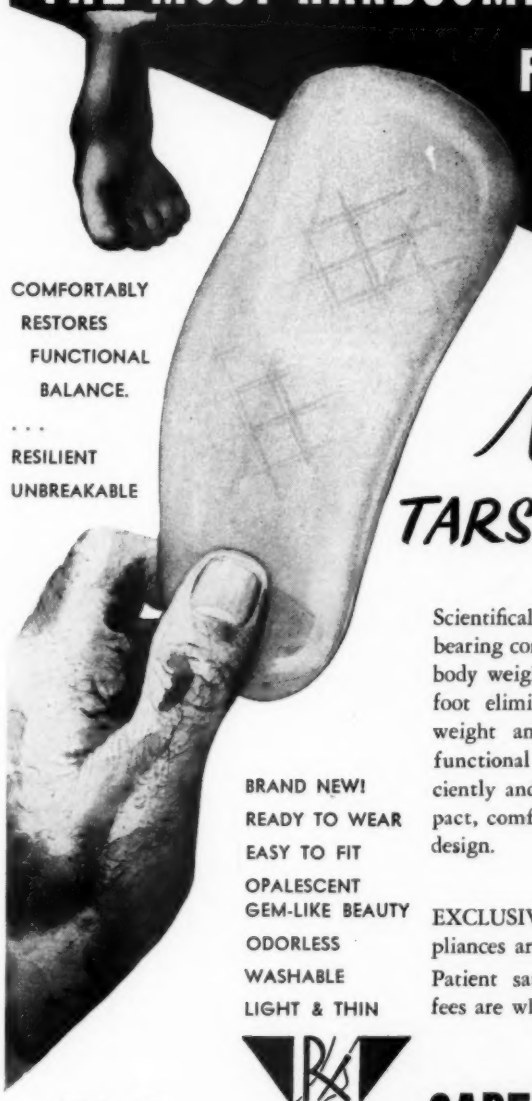

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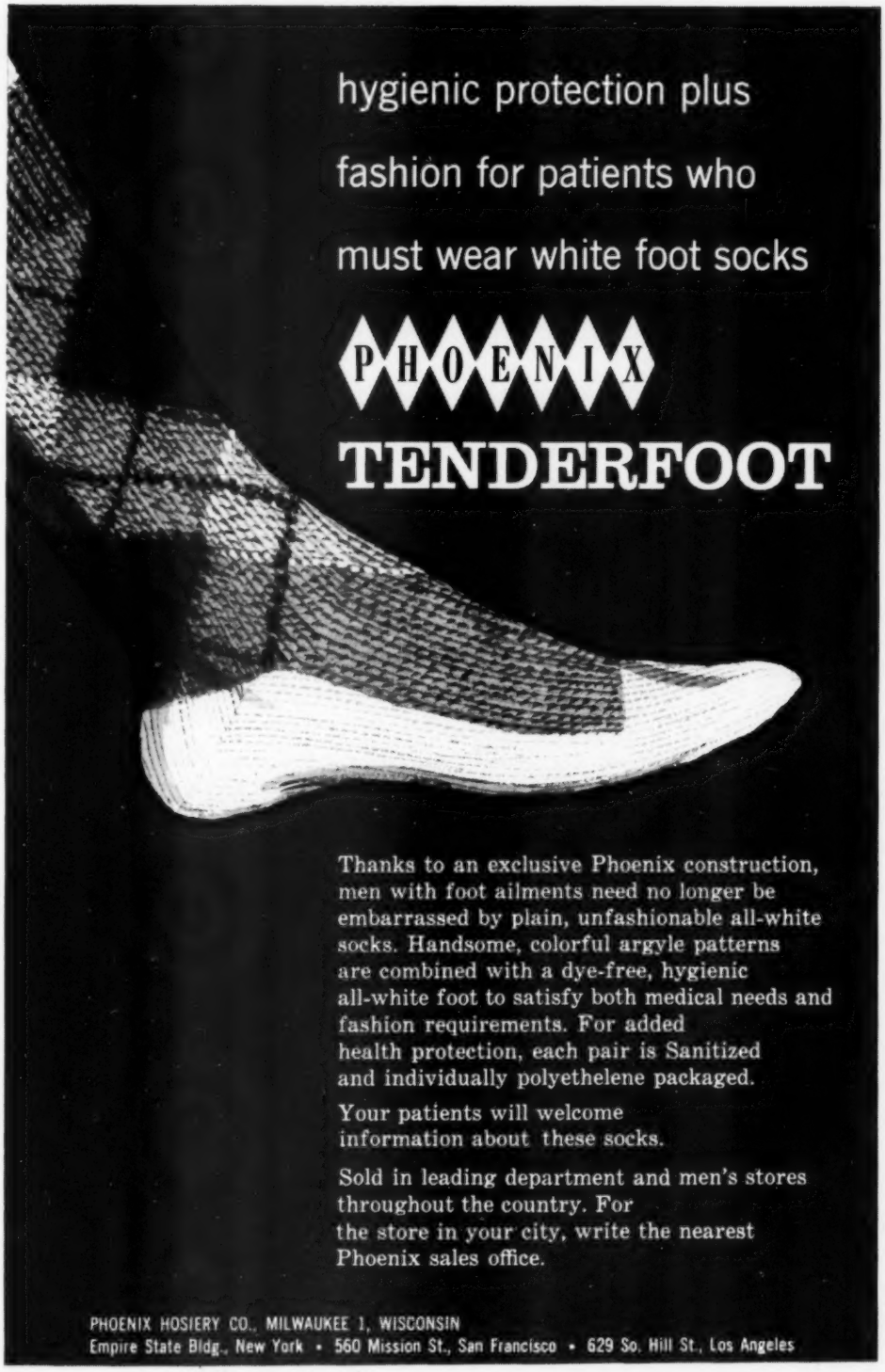

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NEW HORIZONS IN PODIATRY!

See Page No. 99

Helomata durum and molle may be completely and permanently resolved in a high percentage of cases by injection of Keramin, a procedure that was found to be simple and safe for routine use.—This is the conclusion drawn by Bernard Drummer in an article in this issue of the Journal of the American Podiatry Association.

See Facing Page

A new and imaginative technique of administering Keramin in painful plantar lesions is reported by Vern Hall.

These contributions, like the pioneering work of Steinberg[1] and Mullens[2] on the treatment of verrucae and neurofibrous helomata, truly extend the horizons for podiatry's service to the community.

1. Steinberg, M.D., J.N.A.C., *44*, 17(1954)
2. Mullens, B.S., ibid. *46*, 772(1956)

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JOURNAL

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VOLUME 48 MARCH, 1958 NUMBER 3

AN IMPROVED METHOD FOR THE INJECTION OF KERAMIN IN THE TREATMENT OF HELOMA NEUROFIBROSUM

VERN S. HALL, D.S.C.
Waukegan, Ill.

One of the most disabling and painful conditions of the foot that can affect the physical and mental attitudes of a person is the heloma neurofibrosum. It appears not only under the metatarsal heads, but may be found on the plantar surface of the heel, in the long arch and on the medial, lateral, or distal aspect of the toes. One has only to read the history taken from a few of the patients suffering from this painful callosity to appreciate the discomfort they continually suffer.

Very little information as to the etiology and treatment can be found in the literature. The practitioner, having used various medications, electrosurgical modalities, and mechanical appliances, faces treatment of this condition with frustration, knowing that his treatment is most frequently only palliative. The patient no doubt has visited physicians, dermatologists, and a number of chiropodists without avail. Many patients discontinue treatment because of expense and reach a state of hopelessness, despairing of attaining permanent relief.

In March of this year, I had the opportunity to hear a lecture by Dr. Herbert Prentice of New York regarding the fine results obtained with Steinberg's vitamin A solution (Keramin Injection®[1]). I immediately contacted the pharmaceutical house and secured a number of ampules of the solution to test.

Fig. 1: Technique for injection of lesions occurring under the first metatarsal head. The needle is inserted through the relatively soft, thin skin of the side of the foot. It is then directed through the superficial fascia until the resistance of the lesion is felt.

However, I found that the technique of injecting the anesthetic and the Keramin directly into or close to the site of the heloma through the plantar surface of the foot was not tolerated by the majority of my patients. The pain was unbearable. After losing a goodly number, I concluded that there must be a simpler and less pain-

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ful method of administration and decided to inject the solution from the dorsal surface rather than force the needle through the thick plantar area.

Fig. 2: Technique for injection of lesions under the 2nd, 3rd or 4th metatarsal heads. The needle lies in the superficial fascia.

After preparing the skin with alcohol and Merthiolate,®[2] I select a 25 or 26 gauge needle ranging from ½ to 2 inches in length, depending on the thickness of the part and the angulation between the site of injection and the heloma. Ethyl chloride is sprayed on the skin for topical anesthesia. The needle is inserted distal to the metatarsal head into the toe web, or the skin on the side of the foot, until it is stopped by the resistant fibrous tissue at the base of the heloma (See Figs. 1 to 3).

About 0.1 cc. of the anesthetic is deposited into the area beneath the fibrous tissue. If the needle is inserted directly into the fibers it is almost impossible to inject due to their inelastic structure, so I withdraw the needle about ⅛ inch and then inject. Very little force should be used on the plunger. I then free the syringe from the needle. The Keramin is injected slowly through the needle *in situ*.

The dosage is 0.05 to 0.1 cc. depending on the site and size of the lesion. A tuberculin syringe is used to measure the volume accurately. The needle is withdrawn after about two minutes; leaving it this length of time minimizes leakage. A protective pad is then placed on the plantar surface to relieve pressure from the treated area.

Dr. Steinberg suggests one injection weekly for 2 to 8 weeks.[1, 2] However, I have found that the number of injections and dosage is variable and depends largely on the size and duration of the heloma.

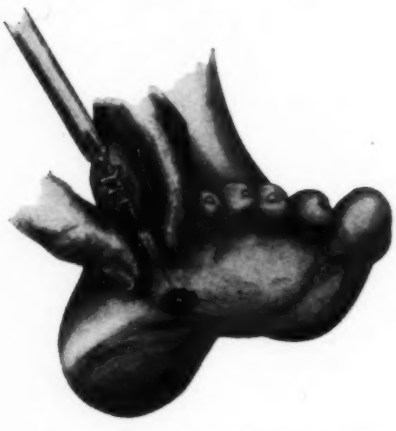

Fig. 3: Technique for injection of lesions under the 5th metatarsal head.

In conclusion, I wish to thank Dr. Steinberg for his helpful suggestions to me. I appreciate the results of research made available through the article by Dr. Benjamin C. Mullens[3] of Binghamton, New York.

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References

1. Steinberg, M. D.: *A New Treatment for Resistant Warts*, Surgery 39, 642, 1956.
2. Steinberg, M. D.: *A New Treatment for Resistant Verrucae*, J.N.A.C., 44:7:17:July 1954.
3. Mullens, B. C.: *An Effective Treatment for Heloma Neurofibrosum*, J.N.A.C., 46:11:772: November 1956.

KERAMIN INJECTION IN THE TREATMENT OF HELOMATA

BERNARD DRUMMER, Pod.D.
New York, N. Y.

IN THE THREE and a half years since the original publication of Steinberg,[1] the use of Keramin®[1] for the treatment of verrucae by direct injection has become quite widely accepted by the profession. More recently Mullens[2] has confirmed Steinberg's findings and extended the procedure to the treatment of the intractable neurofibrous heloma. The purpose of this communication is to report results obtained in the use of Keramin in 21 cases of the various common helomata seen in every day practice. Findings will be evaluated as to, first, effectiveness and, second, practicability of the use of Keramin as a routine procedure.

Procedure: No neurofibrous helomata were selected for this study. The only other criteria for selection was relative resistance to conventional methods of treatment, that is, failure to obtain lasting relief from surface sectioning or caustics. A few patients had not been treated by the author previously but were judged suitable on the basis of their clinical history. The skin surrounding the lesion was anesthetized by spraying with ethyl chloride and then by injecting 2 percent Xylocaine®[2] into the dermis beneath the lesion. Using a fresh syringe and needle, Keramin was then injected at a shallow angle into the base of the heloma. The position of the syringe with respect to the plane of the skin varied with the site of the heloma but was usually almost horizontal. This appears to be important since absorption of the drug from the deeper tissues would defeat the purpose of the injection. The second needle was removed and a simple gauze dressing applied. Injections were repeated at weekly intervals for 2 to 6 weeks as required.

Results: A summary of observations appears in Table I and the cases have been classified in Table II according to the diagnosis and results obtained. It will be noted that all of the 21 patients treated became subjectively symptom free. Of these, 5 showed some vestiges of heloma still unresolved when last seen while in 4 cases appliances were considered desirable, to prevent recurrence. As noted in the table, most of these cases had previously needed regular attention at short intervals in spite of silver nitrate applications, procaine injections and the like. There was no apparent difference between the response of patients suffering from hard, soft or vascular helomata. Inflammation and bursae disappeared when present while hyperkeratosis was either eliminated or greatly reduced. All received benefit significantly beyond their previous response to conventional therapy. No side reactions of any consequence due to Keramin were noted.

The technique is easily learned and simple enough to use routinely. It does, however, require careful attention to detail. Thus, it is worthwhile to make certain that the needles are sharp, and free from hooks. Sterilization should be by heat only and if syringes or needles are stored in antiseptic solutions, these should be thoroughly rinsed out with sterile water before use. *Injections must be given very superficially* since otherwise the vitamin will be absorbed and its local action lost.

Discussion: Helomata seen by the podiatrist take on many outward forms: hard, soft, vascular, neurofibrous, depending on appearance, site and clinical behavior. However, they are essentially the same lesion from an histopathologic point of

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TABLE I—ANALYSIS OF CASES OF COMMON HELOMATA TREATED WITH KERAMIN

Sex - Age	Description of lesion	Previous treatment	No. of injections	cc/lesion	Results: Subjective	Results: Objective	Follow up period since last injection	Appliances used	Side reactions
F-40	Painful heloma durum, 2nd toe, right foot	a Silver nitrate b) Hyfrecation	3	0.3	Symptom free	Thin callus without inflammation	12	None	Itching after first injection
F-50	Heloma durum, 5th toe, right foot	Silver nitrate without relief for any length of time	5	0.2-0.4	Symptom free	Superficial heloma with callus	11	None	None
F-47	Heloma durum, 4th toe, right foot, inflamed, rapidly epithelializing	Failed to respond to anesthetic injections	3	0.3	Symptom free	Slight superficial callus	44	None	Pain for 5 days after 2nd injection, not severe
M-52	Heloma durum, 2nd toe, right foot, painful	a) Shields b) Xylocaine injection	4	0.3	Symptom free	Lesion resolved, no inflammation	None	None	Itching after first injection
M-32	Heloma durum, 4th toe, left foot	Silver nitrate	2	0.4	Symptom free	—	None	None	None
F-28	Heloma durum, 2nd toe, right foot, very painful	Procaine injection	3	0.3	Symptom free	Small callus only	22	None	None
F-21	Heloma durum, 5th toe, right foot	Silver nitrate failed to relieve for any length of time	3	0.4	Symptom free	Lesion resolved	6	None	None
F-15	Heloma durum of two years' duration	None	6	0.2-0.4	Symptom free	Lesions resolved	37	Crests; shoe padding	Mild itching after injection
M-45	Heloma durum, side of 1st toe; very painful	Failed to respond to a) topical chemotherapy and b) procaine injections	3	0.2	Symptom free; pain completely relieved after first injection	Slight callus	None	None	None
F-55	Heloma durum, 4th toe, right foot, 6 years' duration	Silver nitrate without success	2	0.4	Symptom free	Lesion resolved	3	None	None
F-29	Heloma durum, 2nd toe, left foot; very painful	None	3	0.3-0.4	Symptom free	Small callus	6	None	None
F-28	Heloma durum, vascular type, 5th toe, right foot; pain and burning sensation	None	3	0.3	Symptom free	Lesion resolved	16	None	None
F-55	Heloma durum, vascular type, 5th toe, left foot, burning sensation	a) Silver nitrate, and b) Xylocaine injection failed to give substantial relief	4	0.2-0.4	Symptom free	Heloma apparently still present	15	None	None
M-27	Heloma durum, vascular type, 5th toe, right foot; very painful	None	3	0.4	Symptom free	Lesion resolved	6	None	None
F-19	Heloma durum, vascular type; very painful, burning	None	3	0.4	Symptom free	Lesion resolved	4	None	None
M-16	Heloma durum with bursae 2nd and 3rd toes, left foot	a) Xylocaine injection b) Cortisone injection	3	0.3	Symptom free	75% regression	12	Yes	None
F-24	Heloma durum, 4th toe, right foot, inflamed bursa; very sensitive to pressure and friction	Paring which gave relief for 2 weeks only	4	0.3-0.4	Symptom free	Markedly decreased in size; bursa and inflammation gone	18	None	Burning for a few hours after first injection only
M-31	Heloma durum with bursae; 3rd and 4th toes, right foot	Shielding	3	0.3	Symptom free	Lesions resolved	12	Polikof crest	None
F-55	Interdigital heloma, 2nd toe, left foot, extremely painful	Unrelieved by a) silver nitrate, b) procaine injection, c) foam shielding and balance therapy	2	0.25	Symptom free, pain relieved after 1st injection	Exfoliation after 2nd injection; underlying skin normal	20	Yes	None
F-35	Interdigital heloma	Debridement necessary every 2 weeks	4	0.4	Symptoms relieved with debridement every 8 weeks	—	52	None	None
F-35	Heloma molle, 4th and 5th toes, right foot	Debridement and shielding	2	0.4	Symptom free	Hyperkeratotic process regressed markedly	5	None	Pain for 2-3 hours after injection

TABLE II — SUMMARY

Types	
Heloma durum	11
Heloma durum vascular type	4
Heloma durum with bursa	3
Heloma molle	3
Total	21

Results	
Lesions completely resolved, patient symptom free, no appliances required, no recurrence to date of last examination	14
Lesions markedly reduced in size, patient symptom free	5
Patient symptom free but requires prophylactic balance therapy	2
Symptoms relieved only with debridement every 8 weeks	1

view, and have been described by Corson[4] collectively as follows: "Vertical section through a corn discloses an hypertrophied, compressed, corneous layer in the form of a more or less flat cone with its apex inward. The epidermal layers beneath are thinned by pressure and the interpapillary pegs flattened. In the subjacent corneum the papillae are likewise shortened or atrophied by pressure; surrounding the growth, however, they are enlarged and their blood vessels dilated." There is, then, no apparent reason why the neurofibrous type of heloma alone should respond to Keramin Injection and this conclusion has indeed been confirmed by the foregoing results. It was natural that the neurofibrous heloma should be studied first since this is one of the most troublesome lesions with which we are confronted. Nevertheless the injection of Keramin is a conservative procedure which should not be considered as a last resort for resistant lesions, but rather as a valuable tool in any case of heloma which does not show prompt and lasting response to simple mechanical and topical remedies. Naturally no heloma can be permanently cured unless the cause is removed. However, in many cases the removal of the cause is not sufficient in itself to effect a rapid resolution of the lesion. In such cases Keramin has its greatest usefulness in accelerating the repair of traumatized tissue. Where it is not possible or practical to wholly remove the cause, then, Keramin appears to slow down the reformation of the lesion and give the patient a greater comfortable interval between office visits.

Summary: Treatment of hard, soft and vascular helomata by injection of Keramin into the lesion is a conservative procedure and may be recommended for any case which fails to respond promptly to topical medicaments. When properly used this procedure may be expected to cause complete resolution in a high percentage of patients and satisfactory improvement in the remainder.

217 West 231st St.

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"Too often shoe manufacturers influence not only the laity but also doctors with the advertisements of 'proper shoes'.—In general, solid leather oxford shoes of the blucher type with the lace across a tongue are suitable for children. The soles should be thick and flexible. Bootees and soft sole shoes should never be worn."

Frederick Lee Liebolt, M.D.
Modern Medicine, January 15, 1956

ORTHOPEDIC PROBLEMS IN THE FEET OF THE AGED*

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THE Honorable Herbert Hoover, Ex-President of the United States, offered this sound advice on his 82nd birthday, "There is no joy to be had from retirement except by some kind of productive work."

It can be good to retire, but only if the one who retires can continue to perform some useful work either for himself or for others. The person old enough to retire from his occupation, or the person forced to retire, does not often find useful work possible. In order to do productive work, the retired person, first of all, must be in fit condition to do so, that is, his body and his mind must be capable and active, his hands functionable, and his feet able to carry him about.

On the other hand, there are individuals, although old enough to retire, or if not old enough, are physically ready for retirement, who cannot retire because circumstances force them to continue at work. Where is the joy of productive work for these people, if their "feet are killing them"? And what about the individual not yet ready to retire, who wants to be productive, but is forced into retirement because his feet will carry him no further? These people present a problem which we as foot specialists must face. We must keep the aged free of foot infirmity by providing adequate foot care.

"What is life's heaviest burden," asked a youth of a sad and lonely old man. The answer was, "To have nothing to carry." In the word "carry" he inferred an ability to walk. In order to bear a burden, in order to continue in a productive capacity, one must have feet capable of carrying on.

To classify the aged as a group of individuals who have passed adulthood, tells us nothing. The number of years a man has lived does not make him "aged." The aged are those individuals whose various bodily tissues have undergone deterioration to such a degree as to render them functionally poor or inadequate. These persons may be likened to an automobile in which, with passing years, the parts have become worn. The car still runs, but with decreased efficiency; it is slower and not dependable; it breaks down somewhere along the way. Eventually a point is reached where it will no longer run and is beyond repair. Its usefulness at an end, it is discarded. We cannot afford to discard the aged like an old car. We can expect, as part of the aging process, that certain changes will occur within the body which will adversely affect its structure and function, and we must be prepared to prevent or remedy these crippling changes.

The earliest manifestation of such changes is the loss of elasticity of fibrous tissue—in skin, in ligaments, in fascia, and wherever fibrous tissue exists. People recognize this change in the face and sometimes have surgery performed to retard the process or erase its evidence. Yet invariably such alterations are overlooked in the foot where weight bearing stresses effect such a loss of elastic properties.

A second degenerative change we can expect in the aged is partial or almost complete atrophy or absorption of adipose tissue in the sole of the foot. All of us have seen feet in which the bones almost peek through the web of the skin. Little or no shock-absorbing medium remains to protect sensitive osteoporotic bones from the trauma of ordinary weight bearing. When we add this to the particular orthopedic conditions these individuals have "grown up with," or are heir to, this further factor must be considered in therapeusis.

A third degenerative change is reduction

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of muscle potential. The effects of this upon the locomotor apparatus merit careful consideration.

Finally, there are the numerous changes resulting from degenerative processes within the vascular and neurologic systems. These changes are an intimate part of the aging phenomenon; we are well aware of them in the form of the arteriosclerosis obliterans and the severe paresthesias which develop.

But we tend to direct our attention to poor circulation and nerve involvement and the direct results they produce. We observe the gangrene but fail to note the skin atrophy. We see the paralysis, but overlook the weakened intrinsic muscles. We diagnose weakfoot, but not intermittent claudication. We look for the cause of burning feet in footgear, and not in peripheral neuritis. We fail to note the effects of inadequate circulation and nerve involvement upon the various orthopedic conditions which affect the foot. Unless every one of these degenerative changes are considered with regard to function and structure of the foot of the aged, inadequate treatment, and too often contra-indicated treatment, may be employed.

The purpose and the method of treating the aged depends on these physiologic changes. Therefore, one should seriously consider whether it is advisable to employ the same therapeutic measures for treating the aged as are used in young or middle-aged adults. What are the orthopedic conditions which affect people in their 60's, their 70's, and their 80's, and how may they be treated to best advantage?

First, and mainly, these orthopedic disorders may have been carried down through the years from youth to adulthood and into old age, and now are complicated by degenerative changes. Second, there are conditions which appear for the first time during old age.

There is one prevalent group of diseases involving the feet, not originally orthopedic in nature, but whose effects result in orthopedic deformity. These are the arthritides —particularly rheumatoid arthritis. The ravages of this disease process, and the irreparable damage to tissues, produce such deviations and pain that rheumatoid arthritis becomes one of the paramount causes of foot deformity. The direct relation of cause and effect too often is overlooked, and the defect diagnosed as a mechanical condition, and treated as such. Therefore, the process, which is so progressive in nature that each attack brings further deformity, is continued well into the "old age" period. It is imperative that the arthritides be recognized early for what they are, in order to prevent the resultant deformities.

Orthopedic conditions initiated during the old age period are degenerative in type and result primarily from the wear and tear of tissue. This process is noted in osteoarthritis and in the attending stress and strain in tissues which previously could withstand them, and also in the inadequate circulation and its effect upon the viability of tissues and furthermore in the deterioration of nerve pathways and centers. Since nerves supply all tissues, the degenerative results are manifest in all parts of the foot. The resulting poor or inefficient musculature affects posture and gait, as well as intrinsic foot function.

The complications attending orthopedic conditions in the aged must also be considered. Wherever there is pressure on areas of inadequate circulation or disturbed nerve supply, whether this pressure is excessive or not, ulcers are likely to occur.

Because of osteoporosis of bone in these older individuals, fractures tend to occur. They may be spontaneous or may follow comparatively minor injuries. With an insufficient blood supply, even minor corrective measures may induce gangrene. Therefore, whatever treatment is instituted for any condition of the foot in the aged must be done with these complications in mind.

Attempts at treatment should be aimed principally at relief of pain and restoration of function as far as possible. This must be done within the limits the aged tissues will permit, bearing in mind the poor circulation, the inadequate nerve supply, the limited motion, and the many other factors which may complicate the situation. Though the complications are many, and not inconsequential, we can hope to treat these patients successfully by use of preventive measures as well as by local procedures.

Preventive treatment has been little stressed in our own profession, and this is unfortunate. As the noted geriatrician, Dr. Steiglitz, wisely stated, "The pattern of later life is set in youth. If it is sensible for the child to make an effort to learn how to be an adult, it is essential for the adult to learn how to be aged." We should think in terms of teaching young adults to prepare their feet for old age. We must impress upon them the fact that at the age of 70 they will want to get about as actively as they do today, and that the troubles which now beset the feet of the parents or grandparents may be avoided to a great extent in themselves by early preventive care.

The role of preventive chiropody needs clarification, but if we can prevent deformity in children, we can prevent it also in the adult. If we can prevent deformity in the young adult, we can prevent it in the aged. We therefore must institute preventive chiropody in children or, if these measures have been neglected, we must begin with the adult. Today parents are aware of preventive medicine as practiced by the pediatrician and the dentist. We, the podiatrists, have neglected to add ourselves to the list. The same care and attention parents should, and often do, lavish on their child and his feet so that he may grow presently into strong, healthy adulthood is the same care and attention parents must lavish on their own feet if they are to grow comfortably into a healthy old age.

The actual care of the conditions which present themselves should be limited to the relief of symptoms, to the restoration of as much function as possible and to a limited degree of correction where necessary and possible. At the same time, an attempt must be made to build up the general bodily processes and resistive forces.

It may be best to outline what must be avoided in treatment, rather than what must be done:

Avoid Pressure Points: In the treatment of an orthopedic complaint where padding is indicated, pressure upon weight bearing points or bony prominences is to be strictly avoided.

Avoid the Use of Adhesives: These should be avoided wherever possible or feasible.

Avoid Physiotherapeutic Measures Which Produce Heat: Heated tissues in the presence of inadequate circulation, even to a minor degree, can produce ulceration and gangrene.

Avoid Severe Forms of Mechanical Correction: Appliances employed for weight-redistribution, as well as shoe wedgings, should be used with caution, restraint and understanding. Adding strain to any tissue is entirely undesirable in the aged patient, particularly in those no longer able to withstand additional strain. No attempt should be made to force the foot into any new or different position wherever resistance is met —and most often such resistance is met.

Avoid, in General, Forms of Exercise and Manipulation: Exercises are fatiguing, and manipulation of joints that will not give, and of tissues which have lost their elasticity, can be left to those who are heartless.

I much prefer the use of manual massage, tepid whirlpool, and ultrasonic forms of therapy which have proved efficacious

without producing untoward results. Thus, we note three important modalities: massage too often neglected; whirlpool, on the other extreme, too indiscriminately used; and ultrasonic not yet used to any extent.

With scientific advances we have done much to lengthen the span of life, but we have done little to prevent the actual aging process. Instead of extending the "best years of our lives," we have permitted ourselves to slide, ungracefully and unprotected, into old age. The price paid for longevity is the gradual slowing down, the more rapid drying up, and, finally, an almost sudden wasting away. Instead of "Now is the time to retire," the creed of our profession may well be, "Bring your tired and retired persons so that we may make them productive"—so that their future on earth, constantly lengthened, need not be useless, bleak, and hopeless.

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PRACTICAL BUSINESS MANAGEMENT AS APPLIED TO THE CHIROPODY PROFESSION*

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THE DAY of the horse and buggy doctor, who put the bill on the cuff and accepted chickens, corn and potatoes in payment, is long past. Practitioners of the healing arts have been conditioned by a world of business. Our society has a materialistic viewpoint that stems from our very beginning. This materialism has ever been blended with dedication of service. The public today expects of its doctors the same fine service as always, but no longer denies them the privileges of modern economic society. The doctor is granted the right to a standard of living befitting his place in society. The public expects him to equip and maintain a modern up-to-date office and to keep himself well informed as to modern, up-to-date techniques. However much we would like to practice our profession without being being bothered by monetary affairs, unless we take a realistic viewpoint of the fiscal management of our practice, we are going to run into financial difficulties.

What shall be our financial policy if we are to fit ourselves into the economic pattern of today? We must take from the world of business those policies which are applicable to our profession. This brings us to the question of "adequate fees," and how to collect them.

An adequate fee is sufficient remuneration for your services that will afford you the standard of living befitting a professional man—a good home and car, gracious living, and up-to-date working surroundings with modern equipment, that will make your work a pleasure to yourself and your patients. Certainly, an educated, professional man shouldn't have less; and he should not have to work too hard nor too long to achieve this standard of living. We are far short of this ideal, for the chiropodist, in order to experience comparative reward, spends far too much time engaged in his work, in comparison with those in similar professions. This may be one of the major reasons for the failure of a sufficient number of students to enter the chiropody profession. A suggested approach to a possible, partial solution to this prob-

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lem is: Attempt to fit your practice to the standard of living you believe you deserve. But an attempt to fit your practice to a standard of living beyond your potential, can lead to unethical practices and charlatanism.

What then is your procedure in setting an adequate fee and collecting it? First, indicate that you are running your office on a business-like basis. Consider your surroundings from the standpoint of design, lighting, efficiency. If any changes are necessary, make them. Second, your initial contact with your patient should be on the basis of an honest approach to the problem at hand and its solution. Having initiated or completed the proper diagnosis and outline of treatment, discuss: (a) the treatment needed; (b) what it will cost, and (c) how payments should be made. The public wants to discuss fees—"How much will it cost?" A plaque in your treatment room that states, "We will be happy to discuss fees with you," may be sufficient to prompt the discussion.

The first time a patient is in the office is the best opportunity to establish a healthy patient-doctor relationship. But it is at this point that major mistakes are made. The doctor sells the patient on the need for his services, but may not establish the value of that service. Unless proper appreciation for services is established in the mind of the patient, he is apt to evade thinking of services in terms of monetary remuneration. The doctor often neglects or refuses to discuss fees, because he finds the subject distasteful; or he passes responsibility for the financial arrangement to his receptionist—which is neither fair or desirable. Many of those who owe bills will attempt to find justification for their failure to pay them. A patient may rationalize that the service wasn't worth the fee that is asked. Since 95 per cent of the people want to pay their bills, you may content yourself with this percentage. This is not fair, to yourself, to your patients, to a free society. The cash payer is willing to pay his own bill, but not willing to contribute one cent toward the bill of anyone who could, but didn't pay. The cash payer is supporting your practice. A doctor encourages this state of affairs by allowing accounts to drag along.

Distasteful as it may be, you must bring your patient to think in terms of payment of indebtedness. Firmly establish the policy of your office. How are you going to establish a sound business policy?

First, place treatments on a cash basis as much as is possible. A sign in your office, "Treatments are cash," will make known that policy. Large amounts may not be paid at once, but amounts of $10 or less should be paid at the time of treatment. Your receptionist pleasantly states, "That will be five dollars, Mrs. Jones." Nothing more by way of explanation unless solicited by the patient. Whether the indebtedness is $5 or $200, that statement can be made by the receptionist. It is surprising how many will immediately write a check for the full amount. The cash policy will eliminate all of the small problems and 40 to 60 per cent of the larger ones.

Second, of the larger amounts for x-ray, surgical or orthopedic services, about 50 per cent may have to make a series of payments. There should be a definite office policy for this, and should not be left to the discretion of either the office assistant or the patient. For this purpose, you may make use of charts. The down payment should be substantial and should cover your investment in expenses. The balance should be paid in three or four (not over six) monthly installments. Should a patient ask, "May I pay you $5 now?" that patient is bargaining with you. Whenever you compromise it will be to your disadvantage.

Third, regarding collections—to begin with, the cost of mailing statements is not merely a matter of postage and the time in-

volved. Figured in relationship to the total practice, the overhead costs, the amount of bad accounts, their duration of indebtedness, and the number of statements, it is estimated that the cost usually ranges from 60 cents to $1.50 per statement. As stated earlier, 90 per cent of your statements can be eliminated by the cash policy procedure. With the exception of routine reminders to those who make regular payments on account, the collection of accounts receivable is a business in itself. The telephone is the most effective method of collecting from those who neglect to pay their accounts according to agreement. The receptionist, or the doctor, makes a courteous request for an explanation for the failure to pay the bill. This should be done before the next payment is due. Collection devices such as special stamps and forms may work in some cases, but are of no value in others. The use of threatening letters is deplored, as is direct use of the Small Claims Court. They can cause bad publicity. Accounts that are 90 days old should be placed in the hands of a qualified agency for collection.

Fourth, evasion of due consideration for the doctor's services can only bring deterioration of the patient-doctor relationship. In this Age of Insurance, we as chiropodists have frequent dealings with the insurance problems of our patients. If insurance is involved and an intermediary pays the bill, the doctor's service is devaluated. Settle your bill with your patient; except for accommodating him by filling in his forms, let him handle his insurance problems himself. Again, you must evaluate your service; not the insurance company.

As suggested by Mr. Rice, business manager for professional offices in Boise, Idaho: We are conditioned by dealings with a commercial world, and as such we must do business as the commercial world does. Having entered the world of business, we must accept its hazards. Ninety-five per cent of the public dollar is spent commercially and five per cent on health services, including the big share that goes for health insurance. Only a small percentage of the 5 per cent goes for chiropodial care. As a consequence, we engage in competition for the business dollar. Our code of ethics is of no value unless the patient thinks he is the better for our services, his consideration for which determines his appreciation. If we are to share in the economic future of America, we must manage our profession as a business; but as professional men we must not make a business of it!

153 Third Ave. North

RIGID PLASTIC APPLIANCE CONSTRUCTION IN THE OFFICE*

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The object of this paper is to discuss the use of sheet plastics in making appliances and employing techniques suitable for office procedure.

Plastic appliances have certain advantages which make them a worthwhile addition to the orthopedic armamentarium. The beginner will also encounter certain disadvantages. These can all be overcome with experience.

The appeal of the sheet plastics such as cellulose acetate and acrylic is the simplicity of complete fabrication. One piece of raw material cut to proper pattern can become a professional appearing, effective, finished appliance. Even without corrective features, such an appliance made to a model of a non-weight bearing foot, serves as a

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shoe stabilizer and shank reinforcer, and from that standpoint alone has merit.

To enumerate, the advantages of the sheet plastics are:

1. They are thin gauge.
2. Saw easily to pattern.
3. Soften readily in water at 212 degrees F or in an electric oven.
4. Can be readily shaped to model by hand.
5. Corrections and adjustment are easily made.
6. Other reinforcing materials may be laminated or cemented to sheet plastic.
7. Material has over-all flexibility but is basically stable.
8. Finished product is a one piece appliance with minimal bulk.
   (a) Is lightweight.
   (b) Has a smooth glasslike finish.
   (c) Is impervious to moisture and perspiration.
   (d) Is not affected by extremes of temperature, summer or winter.

Taking of impressions can be eliminated. A "shell" or "puddle cast" may be used as a die. The negative lends itself better to plastic "flow" by hand molding than does a positive. Negative molding results in a narrower appliance, easier to fit into the shoe. It eliminates the need for pouring a model (positive). In this case, the completed positive product constitutes a finished appliance. Impression or model imperfection, even slight, may result in appliance distortion and imbalance.

"Balancing" can be accomplished without the necessity of cast correction. Hard felt "build-ups" superimposed on the "negative" may be used instead. Balance may also be obtained by spot heating any portion of the appliance that needs elevating or depressing. Irregular edges may be corrected similarly, that is, heating the involved edge only, instead of reheating the whole plastic form.

Plastic appliances are not dependent on shoe stability to maintain foot balance. They have their own solid shank stability and need only a level heel and ball surface within the shoe. They can be worn, therefore, in a lightweight shoe with flexible shank.

Third dimensional corrections may be added readily to plastic plates. A narrow dorsal convexity can be made opposite the medio plantar aspect of the sustentaculum tali. This is of value where accessory scaphoid or prominent navicular tuberosity occurs and where talocalcaneonavicular control is desirable. Dorsal convexity apposing a cuneiform has considerable value for a foot with hypermobile cuneiform joints.

Some of the disadvantages encountered in using plastics are:

1. Tendency for fracture.
2. Margin of error is less than for nonrigid appliances.
3. Squeaking.
4. Medial flange and anterior border impinge against shoe leather and tend to cut through.
5. Appliances cannot extend much beyond "break point" of the shoe.

Elongated appliances molded from elongated casts are prone to fracture anterior to the calcaneal area. Generally speaking, appliances with contour and structure reflecting models of feet exhibiting poor structure, predispose to fracture. Prevention is accomplished by improving casting or cast adjustment techniques. Stress should be laid on good calcaneal and metatarsal alignment. Sometimes the only explanation for appliance fracture or failure lies in the fact that treatment was insufficient to relax hypertonic muscles. As a result, foot distortion and imperfect contour was eventually impressed in a finished but inadequate appliance.

Even the well-constructed appliance eventually shows the effect of stress factors. Periodic inspection of appliances should be

part of the patient management regimen, and remolding or reinforcement with laminates should be done when necessary.

Although the error margin has to be less than with non-rigid appliances, more enduring postural control may be had with plastics.

Squeaking can be eliminated by cementing shock absorbing materials to the appliance: i.e., celastic, rubber or leather. When this type material is cemented to the anterior border of the appliance, this also prevents cutting into the shoe leather.

Medial flange pressure can be eliminated by spot heating and pressing the medial flange closer to the foot: or the medial flange may be designed with an appropriate "half moon" curve to avoid contact with the waist of the shoe.

If a shell cast or puddle cast is used, an outline of the desired pattern is drawn within the cast with red indelible pencil. The pattern lines are reproduced on paper toweling by first wetting the paper and then pressing into the cast. The paper pattern is cut out and transferred to cardboard. The cardboard pattern is placed against a sheet of plastic and the pattern lines are transferred to the plastic. The sheet plastic form is then cut out with a coping saw using a 35 degree angle of the saw to obtain a beveled edge. The edges of the plastic form are ground smooth on a grinding wheel and sandpaper drum. They are then made waterproof by sealing with acetone applied with a small brush.

The plastic patterns are next placed in boiling water and allowed to soften to a consistency suitable for easy hand molding. Softening may also be accomplished in an electric broiler.

A list of all supplies used plus a list of different plastics suitable for this purpose is as follows:

1. Sheet Plastics
   Cellulose Acetate
   Acrylic
   Acrylic (Rubber Modified)
   Royalite
   Styrene (Rubber Modified)
   Campco
   Polyethylene
2. Coping Saw or Band Saw
3. Gas Burner or Electric Plate
4. Covered Pot for boiling or Electric Broiler with temperature dial
5. Grinding Wheel and Sandpaper Drum
6. Acetone
7. Neoprene, Asbestos, or heavy cloth work gloves
8. Tongs
9. Paper Toweling
10. Cardboard
11. Indelible Pencil
12. Plaster Paris or Plaster Splints

The greatest value of appliance fabrication in the office is the additional opportunity presented to study patho mechanics and develop a concept of ideal structure for a given foot. Cast imperfections are impressed into the plastic appliances. Unilateral differences are easily detected. The distorted, unstable or poorly contoured appliance suffers by comparison with the appliance of better contour and is the end product usually of the more symptomatic foot.

As clinical experience increases, casting technique improves so that cast uniformity and balance eventually become more often the rule rather than the exception. When cast and appliance imperfections do show up, they serve as a "double check" and bring to light patho mechanics that may have been overlooked in the original evaluation of the feet.

With the method described, the plastic appliance molded from the non-weight bearing cast of the foot constitutes a fairly rigid reproduction of the plantar surface of the foot in a static, stable, ideal position. This static position with accent on good structural alignment is a position helpful in assisting the foot function of supporting

body weight and maintaining extensor-flexor muscle balance. Although it does not embrace dynamics, it is the significant position to consider because of the unnatural environment created for the foot by the modern shoe. The shoe is a difficult environment to accommodate to for many feet, not only from the standpoint of dimension and shape but fit under the tread area of the foot particularly. The heel of the shoe assists in the function of propulsion but it doesn't permit normal calcaneal contact with the ground. It doesn't lend itself to the foot function of supporting body weight in standing: and it reduces the support afforded by the ground, to the lateral longitudinal arch.

The rigid appliance must be constructed with all this in mind, and should therefore neutralize the effect of heel height (the reference being even to low heels) in addition to supplying the proper balance and control for the foot.

In summarizing, we have discussed materials with ideal appliance properties. A technique suitable for appliance fabrication in the office has been presented. The process offers economy of time and material. Finally, it offers an additional method of studying patho mechanics and an opportunity to develop a concept of ideal structure for the foot under consideration.

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FOOT HEALTH EXAMINATIONS OF SCHOOL CHILDREN*
Observations Based on Work Done in Illinois

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FROM 1947 until 1954, the Illinois Chiropody Society conducted over 65 separate foot surveys, comprising a total of over 7,000 school children. Our experience may be of benefit to those interested in entering this field of public service. We hope this may give you some of the answers to questions pertaining to the inception and actual execution of such programs.

One of the first questions that is asked is, how does one actually go about starting such a program; or how does one arrange the first school foot examination? The answer is, that this is first arranged through interested friends and patients who are, in some way connected with the school system, or Parent-Teacher Association. Some of you, as parents, in PTA meetings, school board meetings, or through other such contacts, can arouse interest by offering to serve the community in the protection of their child's health through the examination of the feet. This, of course, is offered gratis. When you have aroused interest, the next step is that of organization.

Always go into this service as an organized group, never as an individual. You must do this work through your society or a branch of your society, not as an individual or even a group of individuals. Working as a group you can develop examination procedures, record forms, foot health literature, etc. In Illinois we have developed a number of forms and literature for distribution which are available to interested states. Our forms were based on National Association material, Medical Survey forms, and other State Society materials.

Further, regarding group action as contrasted to individual action, you prevent any possible suggestion of an individual engaging in this activity for personal aggrandizement. School examinations are always conducted for the benefit of the public, never for publicity, never for per-

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† Former Chairman, Health Education Committee, Illinois Chiropody Society.

sonal gain. If we gain as a result of public service it is incidental, not primary. We must be careful to control this policy through organized Chiropody, and eliminate the publicity seeker and selfish practitioner.

Having set up your organization, you are now ready for the necessary and final approval of your survey by the school authorities. You can proceed only on the interest of the parent groups. It is of prime importance that you have permission of the school principal or other school officials. In many areas the school principal has the final word, in other areas you may need the approval of the medical board. This final approval need not come about through your direct efforts; most interested parent groups will obtain this approval for you.

Regarding the actual foot examination, it has been our experience that a screening survey is the only expedient and foolproof method. An attempt is made to screen the normal feet which need no further attention, from those obviously abnormal which should be further examined by the family doctor (that is, the family podiatrist, physician, pediatrician or orthopedist; never, in any case, recommend a particular individual). It is not good policy to attempt a diagnosis, because of the shortage of time, differences of opinion, etc.

The latest and most simple record form in Illinois has only two boxes for checking by the examiner. The top is for the normal feet, with a space for notations, such as:

"Check shoe fit better"

"Nails not being cut properly"

These notes to the parents refer them to the accompanying foot health pamphlet which lists aids and proper foot care.

The other box is for those cases requiring further examination. A notation below explains to the parent that the examiner found some abnormality that should be further studied by the family chiropodist or physician. Our first forms listed many conditions of foot pathology to be checked by the examiner, but this was changed to the simple form because actual diagnoses on the spot are not possible.

Record forms are sent to the schools before examination time and the child comes to the examiner with the top of the form filled out. That is, his name, grade, school and date. In some instances, certain schools wish to follow their own record forms to coincide with their medical and dental forms. In such cases you may either have to use their forms or prepare forms to their standards.

The actual examination is best done in a large room such as a gymnasium or lunchroom, with chairs lined up for the children, and a desk and chair for each examiner. A small table will take the place of a desk. Also a supply of paper towels and receptacle for waste towels should be provided. An examiner can check more than one child at a time. For instance, he observes first the gait and posture of a child in shoes, and while this child is taking off shoes and socks, he is observing another child's gait and posture. He then comes back to the first child to examine the bare foot on and off weight bearing.

The examiner need not touch the feet, he asks the child to spread the toes and observes the interdigital areas and skin. This completes the examination. The examiner makes his notations and dismisses the child, giving him a foot health pamphlet.

The record forms are not given to the child for two reasons. First, the organized group wants to compile statistics from these records, and two, the child may lose the form while bringing it home. The better procedure is for one of the examiners to collect all the forms when the examination is complete, compile the statistics, and return the forms the next day to the school. The forms will then be distributed and sent to the parents in the way other school

material is generally handled. Only in instances requiring immediate attention, such as infections, do you inform the teacher or PTA mothers of urgency in such cases.

In all this work you can expedite matters by utilizing the good services of the PTA mothers to assist in keeping order or helping younger children.

A foot examination is generally followed by an offer to make a talk to the PTA at a general meeting, and to discuss the findings and make suggestions for better foot care.

Foot examinations for children are important to the community and must be a part of organized chiropody's programs for public service.

31 S. Pulaski Road

CIVIC HOSPITAL
A Report of Its First Year of Operation

EARL G. KAPLAN, D.S.C., F.A.C.F.S.*
Detroit, Michigan

Civic Hospital, the first hospital devoted entirely to chiropody, opened its doors on June 3, 1956, at 610 East Grand Boulevard in Detroit, Michigan. It was organized expressly to provide hospital facilities for members of the chiropody profession, to provide teaching facilities, and to provide a training center for surgical internships given to graduate students interested in the surgical phase of chiropody. It was financed by outside interests which believe that public interest demands the fullest development of our professional potential, and recognize the role we must play in the medical field.

In its first year of operation, Civic Hospital has seen nearly 700 cases, of which over 95% were surgical cases (Table I).

The surgical and medical set-up at the hospital parallels that of major hospitals in the United States. On his arrival at the hospital for surgical care, a patient is admitted and given a complete physical examination by a staff medical doctor. This patient is then taken to the laboratory where a complete blood and urine work-up is done and other necessary laboratory tests given by registered laboratory personnel. The patient is then taken to the x-ray department where fluoroscopy, x-ray examination, or therapy is given, as needed, in a department equipped with a 100 M.A. x-ray machine, after which the patient is taken to his room and given an orthopedic 4-hour scrub and prep.

The hospital has the services of two medical doctors as staff physicians for physical examinations and has a consulting staff of medical doctors in general surgery, orthopedic surgery, dermatology,

TABLE I
NUMBER OF CASES
June 4, 1956-June 1, 1957

Arthroplasties (for Heloma Durum or Molle)	621
Nails (Ingrown and Inverted)	432
Bunions	204
Tailor Bunions	41
Neurofibroma	53
Plantar Condylectomies	49
Exostosis	45
Tumors (Soft Tissue)	28
Sesmoidectomy	6
Tenotomies	6
Verruca	5
Bursa	4
Foreign Bodies	3
Tendo Achilles Lengthening	1
Fracture Cases	4
Infections	2
Dermatitis	1

Admissions—Female, 541—Male, 151—Total 692

*President, Civic Hospital.

peripheral vascular disorders and general medicine.

It has a staff which consists of 44 chiropodists who have hospital privileges. The majority of surgery, except minor procedures, is done by qualified American College of Foot Surgery men, numbering 14. The hospital maintains a complete 24-hour registered nurse staff, aides, et al.

It has a full-time kitchen with full-time cooking personnel and also the latest innovations, such as electric dishwasher, garbage disposal (commercial type) and also other sanitation aids which are a necessity in any hospital.

It contains an operating room which is completely air conditioned and a set-up for all types of surgical cases, except maternity, and is equipped with all the necessary equipment (such as oxygen and most electrical modalities) for both general and local anesthetics. The hospital maintains a part-time anesthetist for administration of general anesthetics.

The hospital maintains standing committees, such as tissue committees, record committees, and other committees which are necessary for hospital maintenance to provide complete, authentic patient hospital records, and they are carefully scrutinized and maintained so that each patient's chart will contain a temperature chart, blood pressure, respiratory and pulse records, other necessary notes, progress reports, physicians' order sheets, report of surgical operation forms, anesthetic forms, and complete history and physical forms, along with all the necessary laboratory and x-ray reports. These files are kept at the hospital for reference and study.

Civic Hospital has established the first and only surgical hospital intern training program in the history of the profession, where four men a year – two for each 6-month period–are thoroughly trained in hospital work, both surgical and clinical practices. They have didactic work which consists of lectures in surgical asepsis, anesthesia, materia medica, pharmacology, physical diagnosis, radiography, foot surgery, suturing, pre- and post-operative patient care, laboratory techniques, hospital protocol, instrumentation, method of surgical anatomy, and training in out-patient practice. It should be noted here that the hospital also operates an out-patient department where emergencies are taken care of and other chiropodical treatment rendered. This gives them an understanding of private practice and hospital practice such as is practiced in many diabetic and chiropody departments in other hospitals throughout the United States.

It might be of general interest to note here that the first year of internship was served by Dr. Nelson Pont and Dr. Herbert Bircoll of Detroit, Michigan, who interned at Civic Hospital from June 4, 1956 to June 1, 1957. The two interns serving from July 1, 1957 to December 31, 1957 are Dr. Thomas Fatone of Troy, N. Y., and Dr. Richard Redding of Columbus, Ohio.

Civic Hospital has initiated the first hospital training post-graduate courses in surgery with a faculty from the American College of Foot Surgeons and other allied professions who teach all the latest techniques and present them in a clear, precise manner to the course members. The results have been most gratifying with chiropodists from all over the United States attending and returning home with a greater knowledge of, and enthusiasm for, this phase of patient care.

Civic Hospital extends a cordial invitation to any chiropodist or any student who is visiting or intends to visit Detroit, Michigan, to come and avail himself of the facilities of Civic Hospital by a visitation or by an observation visit.

14608 Gratiot Ave.

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

TARSAL OSTEOPOROSIS

MICHAEL V. SIMKO, D.S.C.
Bridgeport, Conn.

In some instances chance decides an accurate diagnosis. The following clinical report was properly concluded, not by any expansive knowledge of metatarsal conditions by the writer, but, by an injury to the first toe.

Miss Blank, white, age about 30, a teacher, and somewhat obese for her short stature, complained of pain in the forepart of the foot. Repeated visits to a former practitioner who fitted her to a conventional Mayer metatarsal appliance proved fruitless.

Pressure on metatarsal heads and bases of 2nd, 3rd and 4th proximal phalanges brought no special response. Pressure on dorsum caused no discomfort. All motions seemed free. No special pain on standing; rising on the toes proved somewhat uncomfortable and difficult; in other words the patient could not maintain this position for more than a matter of seconds.

Shoe size was beyond criticism, except that it was a pump style and some swelling was evident back of the vamp. Walking on her toes was somewhat easier while wearing the shoes, but difficult without shoes. Principal complaint was pain throughout the dorsum, and extreme fatigue in the foot and legs. At the end of her teaching period fatigue was bothersome. No foot or leg cramps. Pulse, temperature and color about normal.

We advised discontinuing the metatarsal supports, suspecting the appliance crowded the shoe and accounted for the swelling. Instead a 1/8" Denver bar was prescribed. The patient was directed to return in two weeks.

Fig. 1. Tarsal Osteoporosis uncovered by x-raying for suspected fracture (arrow) following injury.

The patient returned with a bruised first toe; the result of a heavy object dropping on her first toe. The swollen discolored toe disturbed the patient but the principal complaint was the continued extreme pain in the back of her legs and a general lameness in the dorsal area of the feet. The Denver bar seemed easier to wear than the braces but did not provide the relief hoped for.

It was determined to radiograph the part since a fracture of the first toe was

suspected. The results proved more serious than a phalangeal fracture or a metatarsalgia, as the following report discloses: "Examination of the left foot shows a comminuted fracture of the terminal phalanx of the first digit, the fragments of which are in good position. There is a generalized osteoporosis of the tarsal bones with osteoarthritic changes of the interphalangeal articulations and bones of the foot, more marked at the first cuneiform metatarsal articulation. There is swelling of the soft tissues of the foot, more marked of the first digit. There are no pathological calcifications or opaque foreign bodies in the soft tissues." (Fig. 1)

Possibly, eventually we would have suggested an X-ray reading, but fate, by way of a contused toe, led to the correct diagnosis.

955 Main St.

RHEUMATOID NODULE

A Case Report

ROBERT S. NICHOLS, D.S.C.
ROBERT L. RUTHERFORD, D.S.C.
Vallejo, Calif.

On November 13, 1957, M.M., a 44-year-old female, reported to the office with a swelling plantar to the third metatarsal head of the left foot. An indurated mass approximately two cm. in diameter could be palpated. The history was of one year duration with increasing discomfort on weight bearing.

The patient was hospitalized and the lesion removed November 25, 1957 through a plantar incision five cm. in length medial to the third ray.

A pathologist's diagnosis of rheumatoid nodule was made.

This report is submitted due to the rarity of such a lesion in this location on the foot.

An uneventful recovery was made and the patient was dismissed December 28, 1957.

327 Georgia St.

FOREIGN BODIES

Case Report

JACK STERN, D.S.C., F.A.C.F.O.
Chicago, Illinois

Mrs. S. G., white female, presented herself in the office on September 4, 1957 with the complaint of pain and swelling of 1st Metatarsal-phalangeal joint R. foot. She had a history of having a stick of wood push through an open toe shoe and irritating the bunion about a month previously.

Examination revealed a Hallux Limitus plus an acute bursitis of 1st M.P. articulation. X-ray examination revealed osteoarthritic changes. No foreign body.

Patient given hydrotherapy at 104 degrees for 15 minutes and a protective Methaguen®[1] dressing applied. September 11th, a report of complete relief of pain and edema, redness had subsided. Hydrotherapy again given and a new dressing applied.

On September 16th, patient returned and complained of severe pain, and edema had returned. ½ cc of 2% Xylocaine®[2] was injected subcutaneously alongside bursa and ⅛ cc of Meticortelone®[3] injected into the bursal sac. On September 23rd, patient returned with a history of relief of pain for 2 days and then an increase of pain. Examination revealed a loss of redness and edema with the joint almost normal in appearance. 1 cc of 2% Xylocaine was injected alongside bursal sac, preparatory to further Hydrocortisone injection. As a wheal was raised, a large tortuous vein protruded over the medial side of the 1st Metatarsal head and shaft, looking like a heavy varicose vein in the leg. One area, approximately ½ inch in length, was very dark brown in appearance. Since the area was anesthetized, a nucleus knife was used to pierce the tissue and the vein. A piece of wood ½" in length and approximately 2 mm in width was removed in toto and a Bacitracin ointment dressing applied.

®[1] Schram Lab. ®[2] Astra ®[3] Schering

Even though the area was anesthetized, the patient declared that a feeling of a tremendous pressure being removed was felt.

Patient returned to the office September 25 with slight pain, no edema, no redness. Upon final examination, October 2, there was complete healing and all symptoms gone.

It is surprising to me that in the many x-rays taken with a foreign body in mind, nothing was seen to demonstrate the possibility of this being in the foot. At no time did the patient notice a skin abrasion after the original incident. Therefore, even this made remote the possibility of a foreign body.

25 East Washington

EVERYTHING BUT YOUR SHOES AND HOSE!

A Case Report of Malignant Melanoma

EDWARD H. BIER, D.S.C., F.A.C.F.O.
Hoboken, N. J.

On July 30th, 1952 Mr. D. C., age 62, presented himself for treatment. His chief complaint was, "I have a sore on the bottom of my foot." Examination revealed that the source of this complaint was a nucleated tyloma under the fifth metatarsal head of the left foot.

Examination of the right foot revealed an area of sloughing tissue, approximately one half inch in diameter, under the fifth metatarsal head. The distal portion of this tissue was still adherent to the foot and the area involved was hemorrhaging. There was a highly pigmented area (gray and black) running dorsally to the third metatarsal, medially to the plantar aspect of the second interspace, anteriorly to include the third, fourth, and fifth toes, and posteriorly to the base of the fifth metatarsal.

Subjective examination revealed that the pigmentation was first noticed by the patient 12-15 years prior to this time. It started as a small, pea size lesion and had spread slowly. The sloughing and hemorrhaging of the tissues under the fifth metatarsal head was of two months duration.

The patient had never experienced pain in this area and objected to the examination. However, we did prevail upon him to permit us to take a tissue sample for biopsy. The sloughing tissue was severed at its attachment and immersed in formalin. Laboratory examination of this specimen verified the tentative diagnosis of malignant melanoma.

The patient was referred to Memorial Hospital in New York City. A Chopart's amputation was performed and biopsy of the stump, and popliteal lymph nodes disclosed that metastases had not occurred.

This case has found an indelible place in my memory because it emphasizes our guardianship of the nation's foot health. Mr. D. C. had been under treatment for a kidney ailment for the past twelve years.

When preparing for a "complete" examination, his physician's instructions invariably were, "Take off everything but your shoes and hose."

417 Washington St.

MORTON'S NEUROMA OF THE SECOND TOE

R. K. SANDEL, D.S.C., F.A.C.F.S.
Columbus, Ohio

Within the past few months two patients have come to surgery with clinical symptoms of Morton's neuroma of the second toe, intermittent severe lancinating pain originating in the region of the second and third metatarsal phalangeal joints. The pain excruciating in character, sometimes radiating to the calf muscle, and of such intensity as to require the removal of the shoe for relief of this pain.

The literature is replete with the above symptoms common to the fourth toe. However, there has been only one case previously reported to this region. The usual

palliative therapy of injection, padding, strapping, and arch supports was tried in these cases without success. One had also received ultra-sound without the results usually attributed to this new form of therapy.

One patient was operated in November 1957, and the other in January 1958. The latter had previously been operated for bi-lateral Morton's neuromas of the fourth toes. Clinical diagnosis and pathology reports in both cases was Morton's neuroma (Perineural Fibrosis).

In the opinion of the writer complaints in the past of severe pain in the region of the second and third metatarsal phalangeal areas could well be considered to be a form of Morton's neuroma, probably traumatic in origin, and subject to the typical clinical symptoms found in the fourth toe.

In a personal communication from Ramon D. Jacobs, D.S.C., F.A.C.F.S., Detroit, Mich., he states, "The frequency with which these problems occur in various locations is greatest between the 3rd and 4th digits, next, between the 4th and 5th digits, occasionally between the 1st and 2nd (especially in hallux valgus with displaced lateral sesamoid bone), and least commonly between the 2nd and 3rd digits. This is not just my own personal experience but is a composite opinion of most of the people with whom I have discussed this."

Patients exhibiting these clinical symptoms, mild or severe, as noted above, can be assured of complete relief following surgery for this condition.

1466 Northwest Blvd.

"To bear up under loss; to fight the bitterness of defeat and the weakness of grief; to be victor over anger; to smile when tears are close; to resist disease and evil men and base instincts; to hate hate and to love love; to go on when it would seem good to die; to look up with unquenchable faith in something ever more about to be—that is what any man can do and be great."

Zane Grey

JOURNAL

OF THE

AMERICAN PODIATRY ASSOCIATION

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PUBLISHED UNDER THE DIRECTION OF THE EXECUTIVE COUNCIL BY THE AMERICAN PODIATRY ASSOCIATION

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A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

PRESIDENT'S MESSAGE

EACH YEAR there are a considerable number of regional, state and local meetings, all of increasing excellence. Much time and energy in our profession (as in all professions and associations) is spent in planning, arranging and conducting these meetings. This time and energy is spent by many people, officers, committee chairmen, committee members, participants on programs and employees. Even those who only avail themselves of the privilege of attending must plan, arrange their practices and travel. Obviously, all this effort must be very worthwhile.

The major purpose of each of these meetings is to present scientific material to their audiences. This enriches the knowledge of those attending so that they may better serve their patients and their community. This is the attraction which causes members to register at these meetings.

Early in the history of meetings, it became clear that good programming and an appropriate registration fee would attract enough members, and commercial exhibitors (a minimum attendance is necessary to make it worthwhile for exhibitors), so that some of these meetings would be financially successful enough to support other activities of the sponsoring group. The fault in this philosophy is that the members who do not attend become the beneficiaries.

Of course a meeting must be self-supporting, unless subsidized. But the desire for a great profit must not be allowed to detract from the very useful and important services a good meeting (conference, conclave, symposium, convention, etc.) must provide.

Since the major purpose is to provide scientific information this must be more than adequately provided for. This will include platform presentations, workshops and clinics. More and better scientific exhibits must be encouraged.

Our meetings must warrant the attendance of technical exhibits. We expect them to share a portion of the cost of the meeting. But they must understand that we encourage their participation not solely for their financial support but because it provides our members an opportunity to see and examine all the latest equipment, devices, instruments, footgear, pharmaceuticals, etc. Our attending members are still further enriched.

A frequently overlooked facet of such meetings is the opportunity that the presentation of the scientific material affords for the best form of public education. We must learn ourselves how to, or, better, seek the services of those specialists who can convert material of the program into professionally and publicly acceptable news stories, and get them published.

Still another opportunity exists. As a showcase of our professional efforts and development, these occasions must be used to acquaint our friends, colleagues, and, more importantly, strangers, in allied and related professional fields and agencies.

Because of the knowledge to be gained from the scientific program, scientific and technical exhibits, because of his participation in the public education and in the improvement of our relation with other groups, each and every member has an obligation to himself, his patients, his community, and his profession, to attend, as a bare minimum, his regional meeting and the annual meeting of the American Podiatry Association. I expect to see in my lifetime a minimum of five thousand attendance at our annual meeting.

As a part of a basic professional philosophy, each member must accept attendance at meetings as a public service in the interest of his patient.

JONAS C. MORRIS, D.S.C.

PARDON OUR ERROR

In the January issue of the Journal in the editorial on page 27, your Editor stated that "The 1957 House of Delegates voted 48 to 16 to amend our Constitution." In some letters to some of our members, he also quoted this figure. On rechecking, your Secretary and Editor finds that the actual recorded vote was 48 to 18 for the change. Please pardon us.

EXECUTIVE COUNCIL TO MEET

The Executive Council of the American Podiatry Association will meet March 28, 29, 30, 1958, at the Shoreham Hotel, Washington, D. C.

HOSPITAL SERVICES

In order to satisfy our national Hospital Practices records and to protect your present hospital status, it is imperative that you promptly complete and return the questionnaire which you will receive from your State Hospital Service Chairman in the very near future.

WASHINGTON REPORT

Congress Considers:

IF CONGRESS concentrates upon the proposed legislation accumulating since January 1, 1957, certain trends of thought appear. Uppermost is concern over the defenses against foreign invasion. Recognition is given to public concern not only over the defenses against foreign invasion with missiles and rockets, but more fundamentally, over the adequacies of our school systems to prepare and interject the services of highly-trained technicians and research workers. Throughout the Session there has been pronounced efforts made for improving our school system and with the opinion of the 2nd Session, this interest has been greatly magnified.

The second interest demanding increased attention from Congress relates to the problems of aging. This is not a new subject either, but as the proposals of those persons who are considered too old for re-employment, beginning with age 40 and reaching a maximum of 65 years, the problems of their care become more complicated. Of course, taxes and the farm problem must not be overlooked. The possibility of tax reduction seems to be growing more remote than it was at the opening of the 1st Session and another attempt at solving the farm problem seems to be crystallizing.

H.R. 9-10—Jenkins-Keogh Bill:

The Ways and Means Committee held a hearing on the Jenkins-Keogh Bill on January 24th. This bill would permit a self-employed individual taxpayer to set aside from gross income annually a limited amount for tax deferment equal to payments made to obtain retirement income for himself. This bill would limit annual payments for retirement deposits to no more than 10 per cent of the net earnings, or $5,000 annually, whichever is the lesser. The total deductions allowed could not exceed $100,000 during the taxpayer's lifetime. The American Podiatry Association, together with the American Medical Association and some other professional groups, supported the bill at the hearing. The American Thrift Association, of which we are a member, represented us and submitted the following statement prepared by our counsel:

The American Podiatry Association wishes to make the following statement with reference to a bill introduced by Mr. Jenkins in the House of Representatives on January 3, 1957 (known as H.R. 4, 85th Congress, 1st Session, also referred to as the "Jenkins-Keogh Bill").

"This Association fully supports the basic principle underlying this proposed legislation, namely, that is in the public interest to encourage voluntary retirement plans for self-employed individuals by means of providing reasonable tax advantages for the particular group of taxpayers affected. It is generally known, that under applicable provisions of the Internal Revenue Code, employees who participate in qualified retirement programs provided by their employers receive substantial retirement benefits usually at a minimum of cost to themselves. Contributions made to such plans are fully deductible by the employer. At the moment, there are no comparable statutory provisions with respect to self-employed individuals. The above-mentioned bill would enable a self-employed person to deduct from his income actual payments made in connection with his own retirement program. At present, a self-employed person desiring to provide for his own retirement, must do so from funds which, in most cases, have been subjected to income tax. From the standpoint of our members and the general public, this bill would correct an apparent inequity. If enacted, this bill would give self-employed persons essentially the same benefits with respect to payments toward their retire-

ment, as are enjoyed by employed individuals in comparable positions."

The Forand Bill (H.R. 9467):

Introduced by Congressman Forand, Democrat of Rhode Island, to amend the Social Security Act, to increase benefits under the Old Age, Survivors and Disability Insurance Program, and to provide against hospital and surgical services for persons eligible for retirement benefits. The provisions of this bill are considered by the American Medical Association, The National Chamber of Commerce and others as socialized medicine and on this basis its enactment is vigorously opposed.

Some of the provisions of the bill are: (1) hospitalization, nursing care and surgical payments for persons eligible for retirement or survivors' benefits under Old Age and Survivors' Insurance. (2) Increase the dollar benefits payable to beneficiaries under Old Age and Survivors' Insurance. The introducers of the bill estimate that 12 to 13 million persons could receive medical protection payments in the first year under this bill. The proposed medical benefits would pay the cost of hospital care for 60 days in any year in semi-private accommodations, and nursing home care up to a combined total of 120 days in a 12-month period. Hospital care could be received only in those hospitals which had entered into an agreement for payment with the Government. Eligible nursing homes would be only those with skilled nursing care and operated in connection with a hospital in which nursing care and medical services are performed under the general direction of persons licensed to practice medicine or surgery in the State. Provision would be made in such amounts as prescribed in the regulations promulgated by the Secretary of the Department of Health, Education, and Welfare.

A National Advisory Health Council would consult with the Secretary of H.E.W. in the administration of the law. The Council would consist of the Commissioner of Social Security, as Chairman, and eight members appointed by the Secretary (four persons outstanding in the field pertaining to hospital and health activities and the other four members to represent the consumers of hospital, nursing home and surgical services).

A retired worker requiring 20 days hospitalization and 100 days nursing home care in a 12-month period could, during all that time receive his bed, board and keep, medical and subsistence care and still continue to receive up to the maximum retirement payment of $151.80 per month.

To finance the cost of this proposal, the base on which wage earners are taxed would be raised from $4,200 to $6,000 and the rates of contribution of employees and employers would be annually increased so that by 1975 the rate of tax for employees and employers would be 4¾ per cent, and 7⅛ per cent for the self-employed.

Senator Proxmire, Democrat of Wisconsin, introduced on January 23rd a bill known as S. 3086 which was referred to the Finance Committee. The purpose of the bill is to amend the Social Security Act, to provide among other things a program of free hospitalization. Senator Proxmire has equaled or outdone all of the provisions Senator Forand had incorporated in his offer to promote government dominance of medical practice. Oral surgery is provided in his bill, if certified as necessary by a licensed dentist. Podiatry or chiropody are not mentioned. Another new feature is an increase in the payments of benefits to individuals receiving O.A.S.I. monthly benefits from the present maximum of $108.50 to $120.70 per month with a maximum of $181.20.

THE PODOPEDIATRIC CLINIC

JOHN T. SHARP, D.S.C.
Chairman, Committee on Children's Foot Health

This section is devoted to a discussion of the problems peculiar to the child's foot. A separate subject will be considered each month. Members are invited to send in their questions relative to the various phases of podopediatrics.

ROTATIONAL PROBLEMS IN THE LOWER EXTREMITY

ROTATIONAL abnormalities involving the extremities are among the more common podopediatric problems. The chief importance of these lesions to the podiatrist lies in their effect upon the gait. Most abduction or adduction gait forms are secondary to rotational discrepancies in the limb. Consequently, any attempt at correcting these ambulatory faults which consider only the foot is doomed to failure.

Abnormalities of rotation in the extremity consist actually in variations of the axial relationship of the parts of the extremity to one another, or in the relationship of the entire extremiy to the pelvis. For example: in rotational problems involving the leg, this structure will be inwardly or outwardly displaced in so far as its axial relationship with the thigh is concerned.

Rotational faults may occur at the hip, thigh, leg, knee or ankle. Consequently, adduction or abduction gait types require careful analysis if they are to be properly interpreted. Such analysis should begin at the hip and proceed distally. At the hip level, internal and external rotational movements are observed in order to ascertain whether or not these motions are within the normal range. Rotational movements of the hip may be most readily checked by having the child seated, with his legs dangling over the edge of the table. The thigh is stabilized with one hand while the other hand forces the leg into abduction and adduction. Motion in adduction tests external rotation at the hip while motion in abduction tests internal rotation. The angle of these motions is taken between the neutral position of the leg and the greatest point of ab or adduction. Motions of at least 45 degrees should be permissible in either direction, and some authorities subtract about five degrees from this reading in order to allow for the mild degree of motion which occurs in the knee joint when the test is made. Tightness in the internal rotators of the hip will of course diminish the amount of external rotation available, while hypotonia in the internal rotators will increase the amount of external rotation possible. The reverse is true as regards tightness or laxity of the external rotator group. It must be realized that disturbances in normal tone and length of the muscles which internally or externally rotate the thigh will produce rotational abnormalities in the exremity, with a corresponding alteration in normal gait.

Rotational problems are commonly observed in the legs of small children, and here again there will be an abnormal variation in the individual's gait. Rotational problems in the leg may be secondary to a twist or torsion in the shaft of the tibia; to a rotation of the leg as a whole, at the knee joint; or to medial or lateral displacement of the foot at the ankle joint. It has been suggested that a "twisting" which occurs in the axis of a given unit be referred to as "torsion," while the turning of one

unit upon another unit be spoken of as "rotation." (1) Most of the adduction cases seen in childhood (the so-called "pigeon-toe" gaits) are secondary to a rotation of the leg upon the thigh at the knee joint. This deformity may be recognized by having the child sit on the edge of a table, legs dangling down in a relaxed fashion. If internal rotation of the leg is present, the foot and the tibial tubercle will be displaced medial to the midline of the patella and thigh. In addition, the plane of the ankle joint will be medial to that of the knee joint. Torsion of the tibia may be recognized with the child seated in the same position. If torsion is present in an internal direction, the foot will be displaced medially when the midpoint of the tibial tubercle is pointing directly ahead. If on the other hand, the foot is placed in a neutral position, so that it is pointing directly forward, the midpoint of the tibial tubercle will be displaced lateral to the midline of the leg. Also seen in tibial torsion of the internal variety is the following phenomenon: with the patient sitting as previously explained (on a table, legs dangling) not only will the foot be medially displaced, but the external malleolus will be more prominent or noticeable than the medial malleolus when the examiner's gaze is directed at the front of the ankle joint.

Kite (2) recognizes two forms of tibial torsion: a congenital form and an acquired form. To differentiate between the two, the so-called "Kite Rotation Test" is used. This is elicited as follows: with the patient supine, the examiner grasps the foot at the heel and rotates the entire extremity inward and outward as far as it will go. Special attention is paid to the movement of the patella during this rotation of the extremity. In *congenital torsion,* medial and lateral rotation are within normal limits. In *acquired torsion,* the patella will rotate inwards to 90 degrees or more as the extremity is internally rotated, but it will roll outward only as far as the midline of the extremity or slightly further as the extremity is externally rotated. Kite also states that there is a more prominent laternal convexity to the leg in the congenital cases.

The cause of rotational disorders of the extremity is not clear. Nachlas has suggested either atavistic reversion or developmental arrest as etiological factors. Since most infants are found to present some degree of internal rotation in the leg, it is quite possible that intra-uterine postures may play some part in the development of this deformity. Most of the acquired cases of internal tibial rotation are secondary to habitually assumed postural attitudes.

The management of rotational problems may be summed up quickly as follows:

1. Proper interpretation of the type of deformity.

2. Control of the deformity with properly applied Denis Browne splint.

3. Strict parental control of habitual postural attitudes of sitting. Any sitting position which forces the foot into adduction and the leg into internal rotation must be discouraged. The same is true of course of external rotation.

The earlier problems of rotation are placed under treatment, the better the prognosis. Since the Denis Browne splint is of value only up to about age four years, other devices such as external rotation braces, twisters, etc. must be used, along with corrective exercise, in the older child. An excellent method of aiding in the control of rotational deformities during gait is the relatively new device known as the "angled heel."

Bibliography:

Rosen, H. and Sandick, H.—"The Measurement of Tibio-Fibular Torsion"—Journ. Bone and Jt. Surg. V.37-A #4, July 1955.

Kite, J. H.—"Torsion of the Extremities in Small Children"—Journ. Bone and Jt. Surg. Vol. 36-A #3, June 1954.

TECHNIQUES IN FOOT SURGERY

L. R. McCAIN, D.S.C., F.A.C.F.S., and N. H. KETAI, D.S.C., F.A.C.F.S.
Editors, Publications Committee, A.C.F.S.

Illustrated case reports and discussions, suggesting approaches to podiatric surgery, from the files of the American College of Foot Surgeons.

SURGICAL PROCEDURE FOR ALLEVIATION OF PAIN FROM A PLANTAR KERATOMA

A WHITE woman, aged 46, seen in the office presented a painful keratoma under the medial plantar aspect of the first metatarsal head of the left foot. This had become more painful over the past months, and palliative treatment would give relief from the pain for only a few days.

Roentgenogram showed a roughening of the medial sesamoid.

Urinalysis revealed the following: color—pale, character—clear, reaction—acid, specific gravity 1.003, albumin—0, sugar—0.

Blood (morphology) indicated the following: R.B.C. 4,300,000, W.B.C. 7,600, Hb. 84%, 12.4 gms., Stabs. 6, Segs. 58, Lymphs 36, coagulation time 2'55", bleeding time 30".

The patient was given 1½ grs. Sodium Seconal ®[1] prior to surgery.

After sterile technic and the application of a Martin Bandage, 3½ cc. of Xylocaine Hcl. ®[2] 2% were infiltrated into the area for anesthesia.

A slightly curved incision approximately four centimeters long was made over the medial plantar aspect of the first metatarsal head, being careful to keep if off any pressure point from the medial side of a shoe. The integument was retracted and through blunt dissection the medial side of the first metatarsal and medial sesamoid were exposed. The space between the plantar aspect of the metatarsal head and medial sesamoid was then determined and an incision made with a scalpel. The medial sesamoid was then dissected free, using the bone for a guide being extremely careful not to sever the flexor hallucis longus tendon. The deep tissues and the medial tendon of the flexor hallucis brevis were then coaptated and sutured with three interrupted 000 chromic catgut sutures. The integument was sutured with seven 000 dermal interrupted sutures. Approximately 1½ cc. of Achromycin®[3] was injected into the wound and sterile pressure dressing applied with Telfa®[4] placed directly over the wound. The patient was given crutches and told to bear no weight on the foot.

The patient was given Empirin Compound®[5] with Codeine Phosphate 1 gr. q. 3 hr. if necessary for pain.

Postoperative treatment was as follows: The day following surgery the outer dressing was removed and sterile dry gauze dressing applied. The patient had slept well and experienced no particular pain. On the fourth postoperative day sterile dry gauze dressing was applied and the patient told she could bear weight on the heel. On the seventh day the entire wound was redressed with sterile dressing. On the eleventh day the sutures were removed, sterile dressing made, and a large accommodative pad placed in the shoe. On the fifteenth day the patient was dismissed; however, the pad was left in the shoe.

Comments: This is a common condition seen in our offices and offers one of the most dramatic and gratifying results of any surgery done by the chiropodist-podiatrist. In doing this surgery, care must be taken not to sever the flexor hallucis longus when the sesamoid is being removed.

L.R.M. and N.H.K.

®[1] Lilly
®[2] Astra
®[3] Lederle
®[4] Bauer & Black
®[5] Burroughs Wellcome & Co.

SURGICAL PROCEDURES FOR ALLEVIATION OF PAIN FROM A PLANTAR KERATOMA UNDER ONE OF THE LESSER METATARSAL HEADS

A WHITE woman, aged 33, seen in the office, presented a painful keratoma under the head of the third metatarsal of the left foot. Her history revealed that she had many forms of therapy used on this, including acids, x-ray therapy, and even surgical removal of the keratoma. There was a cicatrix from the aforementioned therapy.

An axial roentgenograph of the foot showed an enlargement of the plantar surface of the head of the third metatarsal of the left foot.

Clinitest was negative for sugar. The laboratory report indicated R.B.C. 4,530,000; W.B.C. 5,950; Hb. 13.1; Color Index .87; Schilling Count, Stabs 4. Segs. 60, and Lymphs 36.

The patient was given 1½ grs. Sodium Seconal ®[1] prior to surgery.

After sterile technic and application of a Martin Bandage, 4cc. of Xylocaine Hcl. ®[2] 2% was injected proximal to the third metatarsal head.

An incision approximately four centimeters long was made over the third metatarsophalangeal articulation. The tendon of the extensor digitorum longus was retracted medially and the capsule incised longitudinally. The capsule was retracted and a vertical incision made on each side of the joint capsule. The third toe was then flexed, and pressure applied to the plantar surface of the metatarsal head. The head of the metatarsal was delivered out of the wound. The plantar of the condyles was then amputated and the remaining surface smoothed and rounded with a bone rasp. The edges of the incised capsule were approximated and sutured with five 000 chromic catgut interrupted sutures. The integument was then coaptated and sutured with seven 000 interrupted dermal sutures.

The patient was given prescriptions for Demerol Hcl. ®[3] 100 mg. Tabs No. 6. Sig: One tab. q 4 h. if necessary, and Ilotycin ®[1] 250 mg. Tabs No. 8. Sig: One tab q 6 h.

Postoperative treatment was as follows: The second day after surgery the outer dressing was removed and sterile dressing applied. On the fifth postoperative day the above procedure was repeated, and the patient advised she could put weight on the heel of the foot. On the eighth day the entire dressing was removed and sterile dressing applied. On the twelfth day the sutures were removed, Tincture of Merthiolate ®[1] applied, and a sterile redressing made. A ⅜ inch wool felt longitudinal-metatarsal pad was placed in the shoe, also at this time. On the fifteenth day, Tincture of Merthiolate was applied and sterile redressing made. On the eighteenth postoperative day the patient was dismissed. The patient's postoperative care consisted of proper shoes and orthopedic pads.

Comments: This is one of the procedures used for the removal or alleviation of a plantar keratoma under one of the lesser metatarsal heads. In using this, it must be remembered that the plantar of the metatarsal head extends farther posteriorly than the superior surface. It is necessary to remove the plantar aspect of the condyles at least even with the metatarsal shaft.

L. R. M. and N. H. K.

®[1] Lilly
®[2] Astra
®[3] Winthrop

The instruction we find in books is like fire. We fetch it from our neighbor's, kindle it at home, communicate it to others, and it becomes the property of all.

Voltaire

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Empirin Compound with Codeine Phosphate

Description: Highly recommended for analgesic, hypnotic and sedative in podiatry. It has the same properties as codeine and can be given with relative safety except to children.

Dosage: ¼ to 1 grain every 4 hours or as necessary for relief of pain.

Supply: Empirin Compound with Codeine Phosphate No. 1, ⅛ grain; No. 2, ¼ grain; No. 3, ½ grain and No. 4, 1 grain.

Empirin Compound with Codeine No. 1, ⅛ grain codeine; No. 2, ¼ grain codeine; No. 3 contains ½ grain codeine phos.; No. 4 contains 1 grain codeine phos. By Burroughs Wellcome & Co., Inc., No. 1 Scarsdale Road, Tuckahoe 7, New York. In bottles ('Tabloid') of 12, 25, 100, 500 Tabloids each.

Caution: You may only prescribe this item if you have a narcotic license and registration number.

Typical Prescription:
Rx Tabs Empirin Comp. w/Codeine No. 2
Disp. No. XII
Sig: One (1) tablet every 4 hours for pain.

Pantopon

Description: Contains the total alkaloids of opium as soluble hydrochlorides, but free from resins and inert matter. The supposed superiority of the preparation is based on the claim that opium is a better narcotic than morphine, that impurities are deleted, and the compound is soluble and may be given hypodermically.

Dosage: Orally or subcutaneously. 10 mg. (gr. 1/6) to 20 mg. (gr. 1/3)

Caution: Addiction. Dispenser and prescriber must have narcotic license.

Action and Uses: In surgery for control of pre and postoperative pain.

Supply: Pantopon—Ampuls 1 cc (gr. 1/3 per cc) boxes of 12 and 100: Powder, Vials ⅛ ounce, ¼ ounce, ½ ounce, 1 ounce; Tablets, hypodermic, 0.022 Gm (1/3 grain) pkgs. 20 and 100; Tablets, oral, 0.011 Gm. (1/6 grain) vials of 20. By Hoffman-LaRoche, Inc., Roche Park, Nutley 10, New Jersey.

Nartate*

*Nartate is the G. F. Harvey Brand of Dipyrone.

Description: A non-narcotic analgesic and anti-pyretic aqueous solution.

Action and Uses: Nartate seems to answer the need in those indications requiring rapid and effective analgesic and antipyretic action without the disadvantages of narcotic administration. Unlike morphine, Nartate does not produce stupor and sleep; the patient retains his usual alertness and is able to pursue usual daily activities.

Advantages: Nartate provides effective prompt relief which in many cases may be noted within 15 to 20 minutes following administration and persists for 7 hours in the average patient. A low incidence of side reactions. Nartate appears to be free of untoward reactions. Not habit forming. Unlike narcotic agents, Nartate does not produce addiction.

Convenience: Since Nartate is not classified as a narcotic, it does not require the usual narcotic administration and precautionary handling.

Indications: Nartate is indicated for the relief of pain in arthritis, rheumatic conditions, carditis, herpes zoster, post-operative pains, angina pectoris and coronary insufficiency, labor pains, renal colic, gall bladder colic and headache of varied etiology.

Dosage: The exact dosage depends on the condition and identity of the malady. Average dose for adults, one (1) tablet 3 to 4 times daily. Larger doses may be given when required as in arthritis. Children, from ½ to 1 tablet daily. For the relief of acute pain, injections subcutaneously, intramuscular or intravenous in doses of 2 to 5 cc may be used.

Caution: Should not be used where the condition is accompanied by any anemia until such anemia is corrected. Frequent periodic blood counts should be performed especially during the early stages of treatment as a check on the possible occurrence of agranulocytosis.

Supply: Available in 300 mg. tablets in bottles of 100 and 1000 (List 1605) and in 30 cc vials (List No. 1600) containing a 50% solution of Dipyrone in water containing 1.5% Benzyl Alcohol as preservative. Dispensed on prescriptions only. By the G. F. Harvey Company, Saratoga Springs, New York.

Typical Prescription:

Rx Tablets Nartate . . . (Harvey)

Disp: No. L

Sig: Two (2) tablets t.i.d. for 3 days, then one t.i.d.

pHisoHex
(fi-so-heks)

Description: Skin detergent. Antiseptic emulsion containing entsufon, lanolin cholesterols, petrolatum and hexachlorophene 3% on a total weight basis. pH value of the product and its suds is 5.5 same as normal skin.

Action: A very rapid atraumatic degerming detergent of wide application approximately 40% more surface acting than soap. By surface retention, bactericidal and bacteriostatic properties are developed which are cumulative with regular and routine use. Has proved to be non-sensitizing. For use by surgical teams, for preoperative cleansing of the skin or mucous membranes of the patient, for general use in the office and home to prevent cross-infection and for the treatment of open wounds and burns. For economy and best results, pHisoHex should be used from dispensers expelling small amounts.

Supply: pHisoHex (formerly pHisoderm with hexachlorophene), refillable plastic squeeze bottles. Bottles of 5 fl. oz., 16 fl. oz. and 1 gal. Pedal operated 30 oz. wall dispenser and stand, plastic wall holder with full squeeze bottle, wall dispenser with empty 10 oz. glass container. By Winthrop-Stearns, Inc., 1450 Broadway, New York 18, N. Y.

Saratoga Ointment

Description: Contains Boric Acid, Zinc Oxide, Eucalyptol, in a prepared suet and white petroleum base.

Indications: Soothing to surface skin irritations and abrasions. Soothes painful or itching surface skin irritations due to sunburn and windburn, chafing and chapping, minor burns, superficial abrasions, diaper rash, insect bites and stings and for painful or itching hemorrhoids. Harmless to clothing.

Supply: In one ounce tubes and one pound jars. The G. F. Harvey Company, Saratoga Springs, New York. List No. 579.

Peace is not the absence of conflict from life, but the ability to cope with it.

Highways of Happiness

PODIATRY-CHIROPODY ABSTRACTS

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Chairman, Committee on Publications

Editors of Local, State and Regional Publications are requested to provide copies to the Chairman of the N.A.C. Committee on Publications who is preparing this section of the Journal.

VEHICLES OF MEDICATION

Charles A. Newman, Brit. Chiropody J. 9:223-224, (London).

Newman states that when prescribing a treatment, the choosing of a medicament is the primary consideration, but the selection of a vehicle is no less important as one is dependent on the other. The correct choice of a vehicle can mean the difference between success and failure of a treatment.

Newman discusses such common vehicles as baths, lotions, cream, paste and dusting powders.

THE HALLUX RIGIDUS SYNDROME

W. J. Bell, Chiropody Review, 10:19, October 1957, (London).

A syndrome is a set of signs and symptoms which are found in association with a certain disease. With this in mind, Bell describes the Hallux Rigidus Syndrome.

When the first proximal phalanx lies in a straight line with the first metatarsal, its normal range of extension is through an angle of 90 degrees. Anything less than this means that there is limitation of motion. In hallux rigidus there is no valgus deformity of the joint. It has simply lost the freedom of movement in extension. There is destruction of the articular cartilage with a production of periarticular lipping on the dorsal aspect of the joint.

An incipient hallux rigidus is seldom painful. It is usually one of the symptoms which brings the patient to the chiropodist. It may be a corn on the fifth digit which is being caused by undue pressure thrown onto the lateral border of the foot by a limitation in extension of the first M.P. joint. There may be pain above the internal malleolus which may be caused by a transfer of weight. The pain is in that part of the tendon sheath of the Tibialis Posterior which runs upwards for about three inches from the level of the malleolus. Occasionally there is aching up the shinbone as a result of excessive use of the Tibialis Anterior.

These signs and symptoms very often appear months or years before the joint becomes rigid, and give the chiropodist an excellent opportunity to prognosticate the patient's future foot condition.

TUBEGAUZE TECHNIQUE

Brian N. Gent, Chiropody Review, 10:15, October 1957, (London).

Gent describes a tubegauze technique for making permanent removable pads. He first produces a plaster paris cast of the part. One layer of tubegauze is applied directly to the cast, but instead of twisting it at the end, the applicator is left in place within the tubegauze and beyond the end of the toe. The tubegauze in contact with the cast is then painted with latex solution and allowed to dry. A suitable pad is then cut and skived to fit the part to be protected. The base of the pad is painted with liquid latex and, when "tacky," applied in position on the latexed tubegauze. Another layer of latex is applied to the top of the pad. The remainder of the tubegauze is now applied in the usual manner and painted with latex when in position. Finally, when it is dry, it is dusted with a foot powder and trimmed to the desired shape.

INTERMITTENT CLAUDICATION

D. C. Rasmussen, Connecticut Chiropodist, 4:4, October 1957.

The best treatment for the majority of patients with intermittent claudication is active exercise of the muscles of the involved extremity combined with measures to increase the venous return. Increased blood flow is the physiologic response to the stimulus of muscle contraction. Active calf muscle contractions are the most effective. The foot is moved by rotatory movements or by alternating dorsal and plantar flexion, and graduated walking exercises. Improving the venous flexion, and graduated walking exercises. Improving the venous return reduces resistance to the incoming arterial flow. Measures to aid venous flow consist chiefly of (1) maintaining the legs in the horizontal position to minimize venous obstruction, or stasis; (2) calf muscle exercise; and (3) deep breathing exercises.

THE MANAGEMENT AND TREATMENT OF DIGITAL HARD CORNS

L. C. Gibbard Brit. C. J., 10:247-252, October 1957.

The usual sites of digital hard corns are over the interphalangeal joints of the toes or at their apices and such corns are mainly associated with some degree of curling of the toe. This curling may be due either to pressure from short fitting shoes or from overpulling long toe muscles. Gibbard states the main reason for the upset muscle function is to be found in fatigue of those muscles which hold the proximal interphalangeal joints down. He discusses the processes taking place due to the upset in muscle function.

The local treatment for digital hard corns should ideally be considered as an adjunct to correction of those underlying features which are operating against a patient. Presented are descriptions of dorsal interphalangeal pads; multiple dorsal crescent pads for the 2nd, 3rd and 4th toes; buttress pads, single and multiple; and the elastic plaster toe sling for straightening and protecting the apex of a contracted toe.

The successful treatment of digital hard corns is achieved only by controlling a combination of several factors such as proper shoes; muscle function; elimination of weak foot strain; and proper local care.

DIETETICS AND FOOT AILMENTS

C. I. Stewart, The Brit. C. J., 10:253-255, October 1957.

Faulty diet is a direct cause of alimentary toxemia and, since inter-dependency exists between all vital organs, feet suffer along with other parts. Local treatment can only be partly successful if the underlying cause is unattended. Overindulgence in faulty food, improperly prepared, overtaxes the powers of digestion and assimilation and results in auto-intoxication. When this condition exists, it is readily understood why fibrositis and other inflammatory states arise. In the case of feet, it can account for many disturbances involving both hard and soft tissue, aggravating or being aggravated by such conditions as foot strain or sprains.

Stewart states that in four cases of very bad keratosis in both hands and feet it was found that the skin became normal as weight was reduced, as a result of using a high protein diet. A high protein diet for obesity and keratosis is then outlined for your consideration.

BIOLOGICAL THERAPY

Russell H. Seeburger, Chiropody Record, July-Aug. 1957.

"Biologicals" are agents of a complex nature which are used in the treatment and diagnosis of disease and which depend for their action on various phases and relationships of immunity. Under the general classification of biological therapy are

antigens. An antigen is any substance which, when introduced into an animal body, causes the appearance of certain new and specific properties in the tissues and circulating fluids.

Seeburger discusses the Fungus antigens, Trichophyton and Dermatophytin and Dermatophytin (0). The preparation of dilutions for skin injections of Dermatophytin (Hollister-Steer Laboratories of Chicago) is described.

Desensitization injections are usually begun upon the first office visit. Seeburger relates the procedure for patch testing with the antigen and the gratifying results obtained in thirty-three cases.

BOOK REVIEW

ROENTGEN INTERPRETATION OF FRACTURES AND DISLOCATIONS

Joseph Levitin, M.D., Chief, Dept. of Radiology, Mt. Zion Hospital, San Francisco, Calif.; and Ben Colloff, M.D., Associate Chief, Dept. of Orthopedic Surgery, Mt. Zion Hospital, San Francisco, Calif. $7.75, 265 pgs., over 200 illus. Publishers, Charles C. Thomas, 301-327 East Lawrence Ave., Springfield, Illinois. 1956.

The role of the roentgenograms in arriving at early and accurate detection of fractures and dislocations can scarcely be overemphasized. From the rich resources of Mt. Zion Hospital, this superb collection of two hundred diagrammatic illustrations of fractures and dislocations will help clarify your roentgen interpretation of the above conditions found in the lower extremity.

The text is organized in five parts; the third part, covering the lower extremity, is one of the most stimulating and interesting to the podiatrist. In the third part the chapters devoted to the knee, tibia and fibula, thigh, hip, foot and ankle are thorough and should prove of absorbing interest to every practitioner. The section on the fractures of the phalanges, distal and middle phalanges, proximal phalanges; fractures of the metatarsals, neck; fractures of the tarsal bones, and classification of the fracture of the calcaneus and sesamoid bones is well done.

The authors state that, "An effort has been made to show diagrammatically and as simply as possible the position that bones usually assume when they are fractured. They have relied on diagrams to clarify their meaning since some aspect of fractures, particularly the measurement of angles and displacement, are not uniform in texts and journals. The main purpose of the authors is their attempt to describe what constitutes generally accepted satisfactory reduction, with emphasis on the important alignments to be restored or preserved, as an aid to the podiatrist-chiropodist or roentgenologist."

This fine text is not only intended for the roentgenologist, but also for the student and general practitioner of podiatry-chiropody. It does not give the methods of reduction or means of immobilization but does describe in simple language and with the help of over two hundred diagrammatic illustrations, the problems commonly encountered when one is faced with fractures and dislocations.

On the whole, this is a complete, concise, well-written and well-illustrated textbook covering roentgen interpretation of fractures and dislocations. It is a handy compendium for quick reference and should be used by all practitioners of podiatry-chiropody.

Jack Ranzer, Pod. D.

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

DERMATOLOGY, ALLERGY, FUNGUS DISEASES

Dermatologic Aspects of Mycotic Infections, F. C. Licks. J. Med. Soc. New Jersey 53: 473-76, 1956.

The superficial mycoses exist in the keratin of the skin, in the hair and nails and, with the exception of Candida albicans, do not invade the deeper organs; the patient may be unaware of their presence. The systemic mycoses invade the deeper skin and also tend to metastasize to internal organs, often fatally. A large percentage of cases of mycoses is seen by the dermatologist. Proper treatment depends upon identification of the causative agent. The laboratory procedures which consist of direct microscopic examination and cultures are described. Tinea capitis occurs mostly in children below the age of puberty. Children should not be kept out of school because of this disease if it is under treatment. Tricophyton rubrum is found in ringworm affecting the nails, feet, groin, beard and glabrous skin; it is difficut to clear up. The causative agents usually are the saprophytic fungi which are easily identified microscopically. Candidiasis (Monilias and Candida albicans) is revealed in the stools. When bacteria are killed off by antibiotic therapy, the candida and monilia can multiply unimpeded. Nystatin is used successfully to increase intestinal flora. Although Candida albicans can live on normal tissue without causing disease, it can involve the mucous membranes of mouth and vagina and occasionally invades deeper organs. It is prone to attack the debilitated individual. Occasionally other mycoses are found in this state (New Jersey), including sporothricosis, actinomycosis, North American blastomycosis, and cryptococcis; they should be considered in differential diagnosis of obscure cases.

Diagnosis of Mycotic Infections. III. Deep Mycosis of Mucous Membranes, Skin, and Subcutaneous Tissues, D. T. Smith and N. F. Conant. Merck Report 65: 22-24, May 1956.

Maduromycosis is a chronic infection of subcutaneous tissues and bone often occurring in the foot and occasionally in the hand. This infection produces draining sinuses, usually in the foot. White, yellow, red or black granules are found in the pus. Sporotrichosis involves the skin, subcutaneous tissues and lymph nodes, and sometimes the bones and internal organs. Chromoblastomycosis occurs in the form of warty nodules in the skin of the foot and legs, and occasionally the hands. Tinea nigra palmaris occurs on the palms of the hands. These various infections are distinguished by use of specific laboratory procedures.

Suppression of Local Allergic Reactions with Hydrocortisone, A. M. Kligman and W. L. Epstein. J. Allergy 27: 395-97, 1956.

In giving hyposensitizing intramuscular injections of 3-n-pentadecylcatechol it was found that addition of only 10 mg. of hydrocortisone in the same syringe prevented or ameliorated local reactions in some patients. The most consistent results followed the use of 25 mg.—no greater improvement was obtained by increasing that amount. Cortef acetate was used, 1 cc. of which con-

tains 50 mg. of hydrocortisone. Usually hydrocortisone need not be added after the patient has received 300 to 400 mg. of pentadecylcatechol. A group of 46 patients with poison ivy dermatitis was successfully treated.

The Treatment of Resistant Dermatoses with Pantho-F, L. O'Brasky. Connecticut M. J. 20: 633-36, 1956.

Use of 1 per cent alcohol hydrocortisone in a pantothenylol base (Pantho-F) used in 132 cases of dermatitis produced better results than hydrocortisone in other bases. No instance of sensitivity was noted in these patients. The presence of pantothenylol seemed to increase the rate of absorption through the skin. No systemic steroid or other form of dermatologic therapy was used in this series of cases.

MUSCULOSKELETAL SYSTEM

Hypertrophic Osteoarthropathy as an Early Sign of Pulmonary Neoplasm, J. R. Simpson. Harper Hosp. Med. Bull. (Detroit) 14: 118-21, 1956.

Hypertrophic osteoarthropathy, a condition in which periosteal bone formation is the prominent feature, is commonly associated with pulmonary disease. These hypertrophic bone changes usually appear late in the patient having a chronic pulmonary suppurative disease. When they appear early, without easily recognizable lung disease, they may result from a primary pulmonary neoplasm. Clubbing of the fingers is usually an early manifestation of the periosteal changes. A case is reported of an elderly man unsuccessfully treated for two years for disabling arthritis. Slight clubbing of the fingers occurred and swelling of the breast. Roentgenologic studies revealed a localized parenchymal lesion in the right lower lobe. Lobectomy was performed and a pathologic diagnosis was made of adenocarcinoma of the lung. On discharge in two weeks the patient's joint pains had subsided appreciably. Since a number of patients with bone and joint symptoms have been found to have a pulmonary neoplasm, such a possibility should be considered in treatment of patients with hypertrophic osteoarthropathy. Early discovery of an asymptomatic or oncogenic carcinoma makes cure possible, for many of them peripherally located, where chance of recovery is greatest.

A Method of Measuring the Torsion of the Femur in Congenital Dislocation of the Hip in Children, W. Edgren and L. E. Laurent. Acta Radiol. Stockh. 45: 371-76, 1956.

A modification of the Schultz method, devised by Edgren, was used in these cases. After injection of saline solution containing the contrast material (Uriodone 35%) the patient lies on his back on the operating table, hips and knees flexed to 90 degrees, the legs lying horizontally on a support and fixed with sandbags to keep legs parallel and femurs parallel. Roentgenograms are taken with the central ray directed halfway between the hips joints and the symphysis pubis. A line bisecting the femoral head is drawn on the roentgenogram and another line is drawn parallel to the lower edge of the film; the medial angle formed is the angle of antetorsion. Various sources of error and their correction are discussed. The femoral antetorsion was measured in this way in 90 hips of 58 patients aged from one to seven years. A number of these children were operated on later. In 62 cases the result of operative and that of roentgenologic measurements of antetorsion were compared. The operative measurements were 10 degrees higher on an average. But errors of measurements also occurred during the operation, due to a difficulty in fixing the condylar plane parallel with the horizontal plane. A more accurate definition of the angle of antetorsion may be obtained by means of trigonometry with the aid of roentgenograms of the proximal end of the femur in two different planes. The Schultz-Edgren

method is quick and simple and although not exact, it is clinically applicable and gives indications for correction of the antetorsion.

The Problem of Hallux Valgus, N. C. Lake. Ann. Roy. Coll. Surg. 19: 23-35, 1956.

The various theories regarding the occurrence of hallux valgus are: (1) That hallux valgus is a local condition caused by direct pressure of the inner border of defective footwear; (2) that the actual displacement of the toe is secondary to a primary divergence in the metatarsal region, acquired or congenital; (3) that to the primary divergence is added a secondary effect of improper footwear. These beliefs and their proponents are discussed and demonstrated by illustrations. In most cases there is some degree of spreading of the foot in the anterior metatarsal region (splay-foot, spreading-foot), and is shown by x-ray to be due to increasing divergence of the metatarsal bones beyond the normal 15 to 20 degrees, particularly between the 1st and 2nd bone, and occasionally between the 4th and 5th. In most cases of serious hallux valgus there is a considerable rotation of the great toe, causing the nail to look inward, because the attachments of the abductor and flexor brevis muscles and of the deep transverse ligament are towards the plantar aspect of the base of the phalanx. The author believes there is some primary defect in the strength of the attachment of the first metatarsal to the others, possibly an inherent weakness, with incomplete incorporation of this bone with the remainder of the foot. The force applied in walking tends normally to produce splay of the first metatarsal; this is increased by wearing high heels. Depending upon its muscular and ligamentous attachments, the great toe will deviate laterally and at the same time rotate. Once the condition becomes established, pull of the long tendons and ligamentous changes increases and the deformity becomes permanent.

The numerous treatments devised all attempt to bring the metatarsal back into its original position. Some operators prefer wedge osteotomy of the bone; Lapidus, operating at the level of the joint between the base of the first metatarsal, the internal cuneiform and second metatarsal, removes enough bone to allow reduction of the deviation, and establishes an arthrodesis. McBride detaches the insertion of the adductor and flexor brevis muscles from the base of the proximal phalanx, then reattaches them to the metatarsal head. Girdlestone and Spooner remove the digital two-thirds of the phalanx and the joint cartilages and pin the remaining third to the metatarsal head to achieve bony union. Lake detaches all structures inserted into the lateral aspect of the base of the phalanx, excises the lateral sesamoid, and passes a strong suture of nylon or stainless steel through an oblique tunnel drilled into the metatarsal head, and draws the detached structures into the metatarsal head to establish fresh insertion there. The suture emerging from the tunnel on the mesial aspect is fixed at the insertion of the adductor muscle into the base of the phalanx. A complete anatomical restoration cannot be expected from any of these procedures because of secondary changes and contractures.

Aseptic Necrosis of Phalangeal Epiphysis (Thiemann's Disease), J. Iversen. Acta. Chir. Scand. 110: 494-97, 1956.

This rare lesion occurs as a swelling of one or more joints of the fingers, usually the proximal interphalangeal joint of the middle finger, but occasionally occurs also in the toes. Roentgenologic examination shows epiphyseal changes as translucent areas and defects and some compression. Osteoarthritis may develop in the joints subsequently, depending upon the strain

on the joint during the progressive stage. The lesion may persist for years, but a case is reported in which healing occurred within nine months. No treatment is suggested except rest of the digit.

Hereditary Metaphyseal Dysostosis, R. Lenk. Amer. J. Roentg. 76: 569-75, 1956.

The case of a girl two years old is reported with hereditary disproportionate dwarfism and signs of endochondral growth disturbance of the long bones. The child's father and his father and grandfather were all very small and had waddling gait. The growth disturbance of the girl was limited to the long bones which were shown to have insufficient and irregular ossification of the metaphyses. The only case found in the literature in which the disturbance of endochondral bone growth was confined to the metaphyses was reported by Jansen (1934), but the abnormality was considered the result of pressure of too narrow an amnion on the embryo (intra-uterine trauma); there was no evidence of abnormality in other members of the family. In the case here reported, the changes are explained as results of a disturbance of metaphyseal ossification and a biologic heritage from the father and his male forebears.

Relaxant Effects of Meprobamate in Disabilities Resulting from Musculoskeletal and Central Nervous System Disorders; Clinical Observations of Fifty-five Cases, H. E. Gillette. Internat. Rec. Med. 169: 453-68, 1956.

A series of 27 patients with musculoskeletal disorders and 28 with neuromuscular disturbances of the central nervous system caused by prenatal or paranatal injuries to the central nervous system, were given meprobamate (Equanil) as adjunct to psychiatric management. Those with musculoskeletal disorders received a daily dose of from 1.2 Gm. to 1.6 Gm. Of these, 40 per cent were completely relieved and the range of motion restored; 54 per cent more were improved. Those with lesions of the central nervous system received from 1.2 Gm. to 2.4 Gm. daily. Some improvement was noted in 76 per cent of this group. Clinical response to the drug could be observed within a few hours; the greatest effect was reached in four days or less. All chronic patients who improved relapsed after administration of the drug ceased, usually in about two days.

Muscle Tone — A Simple Story, A. J. Buller. Physiotherapy 42: 203-05, 1956.

To explain muscle tone in terms of current physiologic teaching, a review is presented which is concerned with, first, the anatomical components of the stretch reflex arc, and with the tendon reflex or phasic components of the stretch reflex; next, anatomic elaborations explaining the static components of the stretch reflex, the sensitivity of which reflex is considered a measure of muscular tone. The sensitivity to stretch of the muscle spindles is shown to play an important role in determining the effects of an applied stretch. This sensitivity of primary spindle endings is determined by the degree of shortening of intrafusal muscle fibers, and though it is not known whether the relationship between intrafusal shortening and primary ending discharge is linear, it seems certain that one factor determining the output of the reflex arc is the degree of activity in the small anterior horn cells. Apparently, the changed excitabilities occurring in disease processes are the result of alterations in the pattern of descending nerve impulses which influence the activity of the segmental reflex. The conclusion is that if it is true that at least some active contractions of striated muscle are initiated by way of the small motor nerve fiber system, then we find in the spindle circuit a factor common to tone and movement.

Unusual Osteochondroses Presenting Diagnostic Difficulty, H. E. LeBus. Texas State M. J. 52: 596-98, 1956.

A review of the cases of ischiopubic osteochondrosis reported in the literature showed similar symptoms in all cases, differing only in severity. In most cases pain occurs in the hip or groin on the affected side, radiating into the adductor muscles and occasionally into the knee; muscle spasm in the adductors is a consistent finding, and limp is noticeable. In a few cases the temperature and the leukocyte count are moderately elevated. Roentgen examination reveals the lesion at the ischiopubic junction. Benign ischiopubic osteochondrosis belongs to the same group of lesions as Perthes' disease, Osgood-Schlatter disease, and Köhler's disease. It must be differentiated from other lesions occurring at the ischiopubic junction—tuberculosis, acute osteomyelitis, neoplastic disease, reticulosis, and stress fracture. The disease is rare and occurs in children aged 5 to 15 years.

Fracture of the Promontory of the Calcaneus, A. D. Platt. Radiology 67: 386-89, 1956.

Calcaneal promontory is a term applied to the anterior superior margin of the calcaneous, which appears as a ledge-like structure on lateral and oblique roentgenograms. Fracture in this promontory occurs from inversion with plantar flexion, or with acute dorsiflexion of the foot. Roentgenographically, the features of dehiscence of bone with loss of continuity of the cancellous structure and separation of the "beak" fragment are easily recognizable. The fractured surfaces have frayed margins with an absence of cortex in this area. Ten cases were collected from the author's practice. In one patient the fracture had healed, but calcified flecks were present in the bifurcated and dorsal calcaneocuboid ligaments; no other mention of calcium deposits at this site was found in the literature. Disability from healed fracture cases lasts from 7½ weeks to 6 months. The maximal limit of disability in cases of non-union is 15 per cent.

NEW GROWTHS

Sebaceous Cyst: A Modified Method for Surgical Excision, D. C. Belden. U. S. Armed Forces M. J. 7: 1154-56, 1956.

A new modified method for removal of sebaceous cysts was used in a series of 25 patients. None had recurrence or postoperative infections. The method is used in cases where the skin covering the cyst is extremely thin, and where direct incision and dissection would result in rupture of the cyst wall. Following local infiltration of 1 per cent procaine around the cyst area, a semilunar incision is made around one-half the subcutaneous fatty tissue; with blunt scissor dissection, a cleavage plane is made, extending to both limits of the incision. With Allis' forceps the free edge of skin attached to the cyst is grasped and everted. The cyst is everted further and dissection done in close approximation to the cyst wall until approaching the under surface of the skin. A second incision is made matching the first incision but with opposite convexity. A portion of the attached redundancy comes away with the cyst. The clean flat surface heals readily. The walls of the cavity are approximated and sutured, and a pressure dressing applied. The patient applies gentle pressure with his fingers several times a day to the healing surface to prevent postoperative subcutaneous bleeding. The sutures are removed in four to six days.

PHYSICAL MEDICINE; REHABILITATION

The Physiotherapeutic Treatment of Some Congenital Foot Deformities, K. L. Holland. Physiotherapy 42: 206-10, 1956.

This is the third section of a discussion of congenital foot disorders. In the first the history of treatments collected from the

literature is reviewed; in the second, treatment of congenital talipes equino-varus is discussed. Correction of this deformity is done in four stages during the first to tenth week of treatment; then maintenance of the corrected position is continued from the second month to one year. This is followed by training in walking and exercises. The third article described treatment of congenital talipes calcaneo-valgus, which begins in the first week to second month of life. Congenital metatarsus varus is treated either from birth, or can be treated at the ages of one to four years. Treatment of curling toes is also described.

In all, 234 children with various types of congenital foot deformity were treated. Of 80 with talipes equino-varus, excepting 13 whose treatment was continued elsewhere, all showed satisfactory results, or are still under observation. Of 52 with congenital talipes calcaneo-valgus, all showed improvement, but a number showing signs of improvement stopped treatment. All of the 53 with metatarsus-varus excepting 14 who stopped treatment are improved but are still being treated. Of 49 with curling toes, all of the younger group are cured or improved; four over six years of age showed no change and a later operation is being considered. Treatment of these various deformities should begin early and full correction obtained as soon as possible, and the foot held in corrected position by strapping until the child begins to walk. Exercises to strengthen the muscles are continued until there is no danger of relapse.

RHEUMATOID DISEASES—ARTHRITIS

The Collagen Diseases: Their Common Characteristics and Their Nature (With Particular Reference to the Rheumatic and Pararheumatic Disorders), W. S. C. Copeman. Acta Med. Scand. 312: 265-74, 1956.

Among the collagen group the author includes rheumatic fever, rheumatoid arthritis, polyarthritis nodosa, disseminated lupus erythematosus, scleroderma and dermatomyositis. Connective tissue is made up of cells and intercellular substance; the latter (a homogenous ground substance and fibers) is called collagen. In collagen disease there is a general alteration in connective tissue, particularly in the intercellular substance. No common etiology in these diseases has been found. The clinical features of polyarthritis nodosa, dermatomyositis, diffuse scleroderma and lupus erythematosus diffuses show the limited types of pathologic changes which occur, varying only according to the organ involved. The course of collagen diseases may be acute or subacute, with a tendency to remissions. Clinical signs may be observed in the heart, serous membranes, joints and blood vessels and the lymph glands and spleen may be enlarged. The blood vessels in rheumatoid arthritis are rarely enlarged, but are constantly affected in periarteritis nodosa. Whereas serous changes are common in disseminated lupus erythematosus, they are common in rheumatoid arthritis. The pathology of joints and joint fluids may be identical in disseminated lupus erythematosus and rheumatoid arthritis, making it difficult to disprove the coexistence of rheumatoid arthritis in disseminated lupus erythematosus. Joint pain and swelling are present during some stage of all collagen diseases. They are the presenting symptoms in most of these diseases, except in scleroderma in which joint involvement is due to contracture of the surrounding structures. The only symptoms found common to all these disorders are those referring to the musculoskeletal system. For this reason there is a tendency to call this group the pararheumatic diseases. Cortisone and ACTH prove of value in all these disorders, but actual cures have not

yet been proved because of the fewness of cases reported, and because of spontaneous remissions which occur.

Pain in Osteoarthritis–A Working Hypothesis as a Basis for Treatment, J. McM. Mennell. Med. Ann., District of Columbia 25: 495-501, 1956.

Osteoarthritis is a painless change in the synovial joints. The pain accompanying these changes can be relieved, but the changes persist. The most frequently prescribed treatments, such as exercising the muscles, supporting the joint, intra-articular injection of a drug or acid, physical therapy including some form of heat, reconstructive surgery, or even joint fusion, are all attempts to extend the range of movement of the affected joint or, in the case of fusion, to destroy movement of the joint. Impairment of movement, next to pain, is the most common symptom. In all synovial joints there is a secondary movement, or "joint play," not in control of voluntary muscles. Movement in the voluntary range is dependent upon the integrity of this joint play. Voluntary movement can be restored and pain relieved only after restoration of the lost movement in the voluntary range. Only application of some imposed mechanical force by use of manipulative techniques or by some accidental movement will be restorative. An unguarded voluntary movement in a joint may exaggerate a movement in the involuntary range and produce abnormal stretching of a ligament, causing muscle spasm and pain. The joint-lock continues until restoration of joint play, which allows free movement of the joint. Once pain in osteoarthritic joints is relieved, recurrence can be prevented by prophylactic measures. The best method is use of exercise without weight-bearing, or in nonweight-bearing joints without the strain of too early use. Atrophied muscle can be redeveloped by use of hand-surged faradic stimulation preceding active exercises without weight-bearing. Restoration of joint movement is necessary before reeducation of the muscle can be attempted. The hip and knee joints are more often affected than other weight-bearing joints, such as those of the foot, ankles and spine, because these joints have a better distribution of load through a multiplicity of joints. Prophylactic management of osteoarthritis from a musculoskeletal viewpoint begins with the footwear and feet of the patient and works upward. The problem, then, of management of the patient is (1) maintenance of body weight to that which the damaged joints can be expected to bear without further undue wear and tear. There may be some relation in water balance to osteoarthritis as such patients usually are deficient in daily fluid intake. (2) Avoidance of any focus of infection and eradication of any focus present, though focal infections are not primarily the cause of symptoms in this disease. (3) Removal of the patient from any occupational hazard and institution of vocational rehabilitation. (4) Persuading the patient to sufficiently rest the damaged joint every day, yet maintaining the integrity of the muscles. A combination of therapies is suggested: (1) the injection of the painful joint with lactic acid according to the size of the joint (maximum is 8 cc.. for the hip joint); (2) manipulation of the joint while the joint is analgesic and cushioned, and while the capsule is stretched.

Pathogenesis of Gout, S. J. Thannhauser. Metabolism 5: 582-93, 1956.

An extensive review of the literature was made to evaluate three different mechanisms suggested as bringing about uricemia in gout: (a) decreased uricolysis in intermediary metabolism in the organs of man; (b) increased uric acid synthesis in the intermediate metabolism, and (c) dysfunction of the mechanism of uric acid transport by the kidney. Since uricolysis does not occur in man, diminished uricolysis cannot be a

factor in gout. Increased synthesis of purines and uric acid from small molecular metabolites cannot be considered as the cause of hyperuricemia in gout since it has been demonstrated that the purines are not directly synthesized from small molecular metabolites, but are synthesized in the organism by a complicated enzymatic synthesis starting from a ribosepyrophosphoric ester compound. Moreover, studies have demonstrated that nucleotides (purine-ribosyl-phosphoric esters) are not elevated simultaneously with serum uric acid in the gouty patient. Such an increase of nucleotides is found, however, in the serum of leukemic patients. Normally, 90 per cent of the uric acid in man is reabsorbed from the glomular filtrate. Although tubular reabsorption varies in the healthy man, it remains at such a high level in the gouty person that hyperuricemia becomes permanent and uric acid is precipitated in the tissues. The aggravated unfavorable condition in the gouty person for elimination of uric acid leads to hyperuricemia and depositions of urate. But increased reabsorption of uric acid is a functional disturbance which is reversible, for uricosuric substances, such as atophan and especially benemid, decrease the reabsorption of uric acid. Thus, elimination of uric acid is furthered by increasing the concentration of uric acid in urine without diuresis. The author therefore maintains that the pathogenesis of gout is a functional disturbance of uric acid transport by the kidney.

SURGICAL ARMAMENTARIUM

An Emergency Set to Combat Anaphylaxis, L. E. Prickman and K. A. Lofgren. J. A. M. A. 161: 1159, 1956.

A substance should not be used in treatment of a patient who has even a questionable history of hypersensitivity to it. But anaphylaxis can occur unexpectedly. Anaphylactic sets have been provided for such accidents at the Mayo Clinic. These sets each contain two ampules each of 1 cc. of epinephrine (Adrenalin) 1:1,000 solution, and of aminophylline (3¾ gr. or 24 gm.); one 10 cc. ampule diphenhydramine (Benadryl) hydrochloride (10 mg. per cc.); one ampule sterile water; one ampule absorbable surgical suture (catgut) with needle; two 2-cc. syringes; two hypodermic needles (1 inch and 4 inches long); one 20-cc. syringe; one 1,000 cc. bottle 5% solution dextrose in distilled water; one bottle hydrocortisone (dilution to 2 cc. gives 50 mg. per cc.); one intravenous set; one scalpel, one hemostat, alcohol, gauze sponges, swab tongue blades. An oxygen tent and mask must be easily available.

X-RAY

Safe Exposures in Cineradiography, H. M. Harper and S. J. Reynolds. British J. Radiol. 29: 461-62, 1956.

Indirect cineradiography has been considered a dangerous procedure to the patient, and, moreover, one that places excessive strain on the x-ray tube. A technique is described which provides films of satisfactory quality without danger of overdosage.

Additional Projections of the Os Calcis, M. O. Chesney. Radiography 22: 53-55, 1956.

Eight types of fractures of the os calcis have been described. Radiographs should show the type of fracture present, the course of fracture lines and the direction of displacements. The condition of the sub-astragaloid articulation must be known in order to plan treatment. Two projections are described in the radiographic examination of such fractures: (1) the modified axial view, with the central ray directed through the anterior end of the os calcis; (2) the lateral oblique with the central ray beam tilted caudally 30 degrees from the vertical, directed between the malleoli and passing just below the lateral malleolus as it emerges. Illustrations depict the difference between the routine lateral and axial views, in comparison with the two modified views. The gross disruption of

the joint line is shown more clearly in the latter views.

MISCELLANEOUS

Entertainment Expenses Are Deductible —Maybe, M. F. Cahal. G P 13: 135-36, April 1956.

Professional entertainment expenses are listed on Schedule C-2, entered on line 21, and the total deducted from gross profit then entered on line 8 of the first page of Form 1040. The Internal Revenue is carefully checking claimed deductions for entertaining expenses; satisfactory evidence is demanded. Club dues and expenses are not deductible unless it is proved that the business of the taxpayer is improved thereby. In some cases a proportion of the total expense is allowed, when the taxpayer used the club 50 per cent of the time to entertain clients, and for other purposes associated with his business. It is often difficult for doctors to provide such proof. A doctor must convince the collector that the expense incurred was in reasonable anticipation of professional benefit. All entertainment expenses including gifts may be deductible if they meet the proper test—for professional, not personal, benefit. It is well if the doctor can prove it benefited practice, such as a general practitioner showing he entertained a specialist who subsequently referred a patient who needed a family doctor. It is most important to keep accurate records with adequate explanations of every claimed deduction.

The Role of Mediators in the Inflammatory Tissue Response, W. Feldberg. Internat. Arch. Allergy 8: 15-31, 1956.

"Mediators in the inflammatory tissue response" is a phrase coined by Menken in 1953. The question is raised here whether there exist special pain substances which act as mediators of the pain sensation in inflammation and if so, what they are. The possible inflammatory tissue response to the following mediators is discussed: histamine, hyaluronidase, polypeptides such as bradykinin, leukotaxin or exudin, and globulins such as necrosin (the euglobulin fraction of inflammatory exudate). Although each may play a role, no single biochemical agent seems to produce the complex inflammatory tissue response. Although each mediator has a special effect, no mediator rivals the other; all may reinforce one another. The conclusion is that the mediators may be naturally occurring tissue constituents which become activated when released, or they may be substances which are first formed by some enzymatic process. The first step in the events which follow would then be the activation of an enzyme or activator. The findings of many experimenters working with these "mediators" are reviewed, but the problem of their role is left unsolved.

"Karl Marx called religion the opium of the people. Arnold Toynbee says that when a man divorces his daily work from his religion the results are invariably calamitous. Our American way of life is based on the philosophy underlying the latter concept."

Joseph C. Kauffman

THE WILLIAM J. STICKEL MEMORIAL AWARDS FOR RESEARCH IN CHIROPODY FOR 1958

Sponsored by the Journal of the American Podiatry Association and The NAC Agency, Inc.

RULES AND PERTINENT INFORMATION

1. Awards will be offered for papers on Research in the field of Chiropody.
2. Monetary considerations provided are as follows:
   First Award—Four Hundred Dollars
   Second Award—Two Hundred Fifty Dollars
   Third Award—One Hundred Dollars
   Fourth Award—Fifty Dollars
   Fifth Award—Fifty Dollars
3. Manuscripts will be judged by a Committee appointed by the President and the Executive Council. The Committee is authorized to withhold the granting of Awards in the event any or all papers submitted are considered to be of insufficient merit.
4. Recipients of the Awards will be announced at the Annual Meeting of the Association in 1958. Any author may be requested to present his paper at the Annual Meeting.
5. All papers received become the property of the American Podiatry Association and shall be available for reproduction in any publication sponsored by the Association. Papers must be original and all rights with regard to publication are assigned to the American Podiatry Association. The originals of all submitted papers and manuscripts will be placed in The Wm. J. Stickel Memorial Library and Museum.
6. Papers entered must be in the hands of the Secretary by May 1, 1958.
7. Manuscripts should be typewritten and double-spaced. No limits or restrictions are imposed on the number of words, use of photographs, charts, etc. Photographs, diagrams, drawings, statistical charts, etc., will be of value in presenting the subject of your choice.
8. Manuscripts should have no personal references in the body of the paper and the name of the author should appear only on a cover sheet. This is to enable the judges to review the papers anonymously. Each paper will be assigned a number for judging purposes.
9. All inquiries concerning the Awards should be addressed to the Secretary. Members desiring to submit papers must make application on a form provided for that purpose which can be obtained from the Secretary.
10. Authors may be required to submit a synopsis, abstract or report of their presentation. This will be for publication in the *Journal,* or for reading at the Annual Meeting, should it be desirable but impracticable to publish or read the original.

Contributions from The NAC Agency and from J.A.P.A. provide the Awards for 1958.

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

ARIZONA

The annual meeting of the Arizona Chiropody Association was held on Sunday, January 5, 1958 at the Westward Ho Hotel in Phoenix. Officers elected for 1958 were: President, Dr. Martin Snyder of Tucson; Vice President, Dr. Abe Stern of Phoenix; Secretary-Treasurer, Dr. Irwin D. Shapiro of Phoenix. The scientific session, following the business meeting, included a demonstration of the contour mold shoe and sandal.

ILLINOIS

The Illinois Society has been sponsoring a Foot Health Exhibit for the Museum of Science and Industry in Chicago. Proposed exhibit has been accepted by the museum and approved by the Medical Advisory Committee. Total cost of the exhibit will be $10,000. The Illinois Chiropody Society will welcome any contributions to the fund for this exhibit. Several million people from all over the United States visit the museum annually.

Dr. Harold W. Seeber was installed as President of the Rockford Kiwanis Club. Dr. Seeber is also President of the Inter-Club Council; President of The Winter Theater Association; Past President of the Radio-T.V. Council; Director of the Rockford Music Festival Association; Chairman of the Civic Events Committee of the Chamber of Commerce for two years; President of St. Paul Lutheran Church and Past President of Northern Illinois Chiropody Society, now Program Chairman.

NEW MEXICO

At the annual meeting of the Society, the following were elected to office: President, Dr. Paul Stevens; First Vice President, Dr. Miller Lane; Second Vice President, Dr. E. Lenore Morris; Third Vice President, Dr. Michael Gross; Secretary, Dr. Charles W. Boesenberg. All are Albuquerque podiatrists.

At the same meeting, the New Mexico Chiropody Association became the New Mexico Podiatry Society.

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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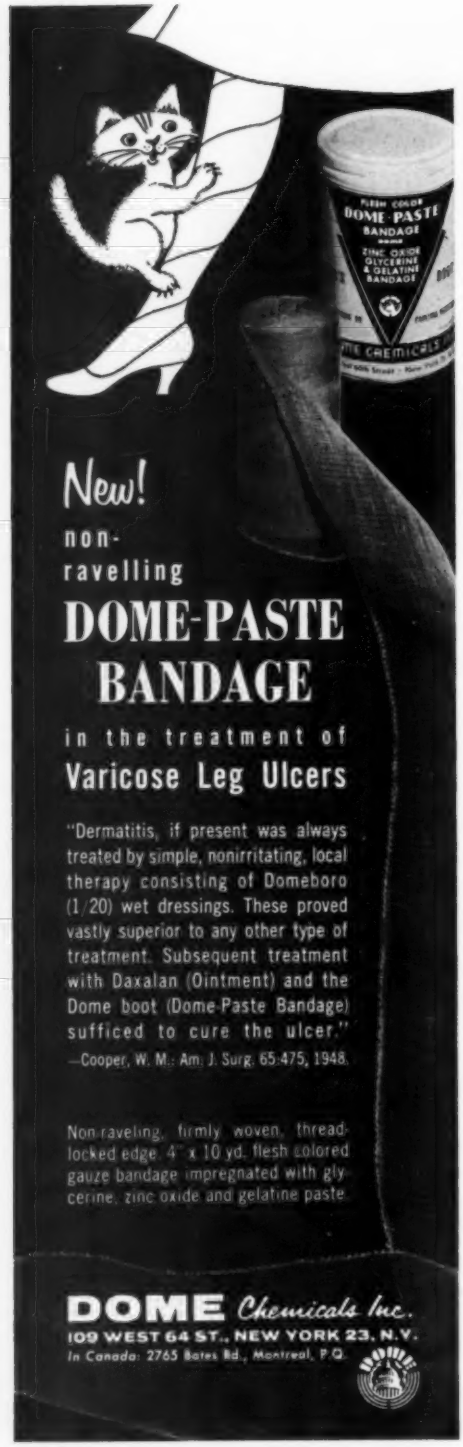
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NEW YORK

A new Industrial Foot Health folder, which has been well received, is now ready for distribution to the membership at large. The pamphlet, created by the Queens Division of the Podiatry Society of the State of New York, is called KEEP YOUR FEET WORKING and is a four-page folder with illustrations.

The rates are 100-400 folders @ $3.00 per hundred and 500-1000 folders @ $2.75 per hundred.

If any state division or member requests a sample, please send request and stamped, self-addressed envelope to Dr. Murray B. Goldstein, Secretary, Queens Podiatry Society, 141-49 73 Avenue, Flushing 67, New York.

The drive towards the achievement of another major Podiatry Society goal—foot health examinations for all school children—moved ahead with the appointment of Dr. J. Lee Carrel to the special Advisory Council on Health Services of the New York State Education Department. The Advisory Council which had been composed of representatives of medicine, dentistry, nursing and public service groups has now been expanded with Dr. Carrel's appointment to include a podiatrist.

Dr. Irving L. Marks, President, and Dr. Benjamin C. Mullens, Public Information Director, headed a committee which met with State Education Department officials to urge inclusion of foot care within the school health program of New York State. The appointment of Dr. Carrel was the result of this meeting.

Dr. Carrel, a Buffalo practitioner, has been President of the Western Division of the Podiatry Society and also has been an active member of the Workmen's Compensation and Hospital Qualifications Committees of the Podiatry Society.

One thing that keeps a man from holding his own is the Internal Revenue Department.

NORTH DAKOTA

Dr. J. E. O'Brien of Bismarck, N. D., standing, and Dr. T. W. Cockrell of Minot, N. D., right, discuss with the Governor of North Dakota, the Honorable John E. Davis, the change in name of the National Association to the American Podiatry Association and the North Dakota Association of Chiropodists to the North Dakota Podiatry Association.

PENNSYLVANIA

Philadelphia

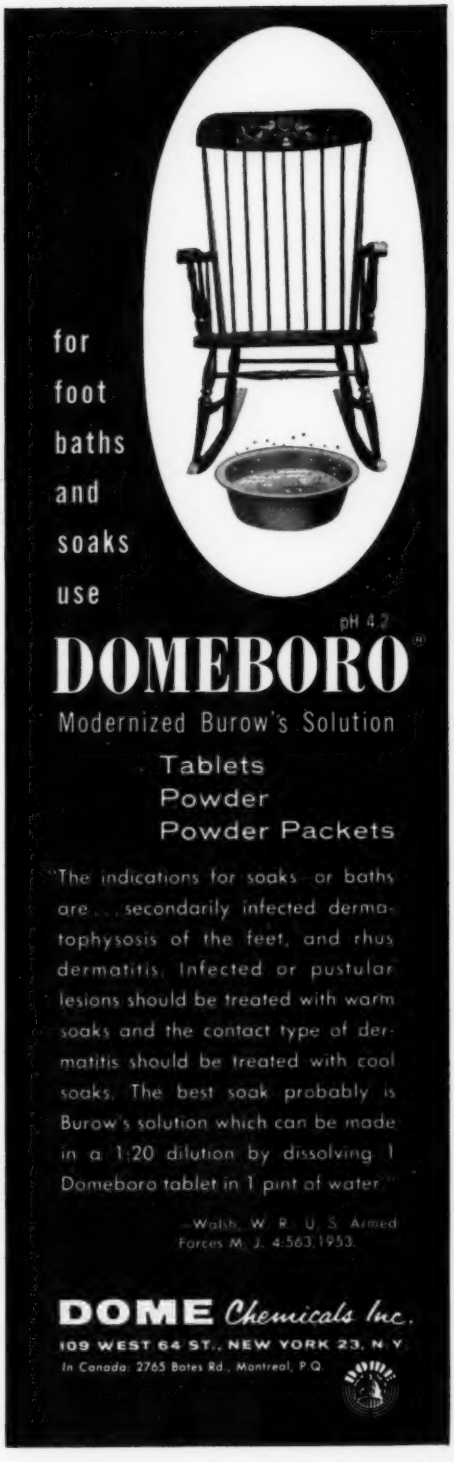
On January 21, 1958, the monthly scientific meeting of the Philadelphia Chiropody Society was held at the County Medical Society Building. The guest lecturer was Russell A. Anthony, M.D., of the Philadelphia Association for Psychoanalysis. Dr. Anthony spoke on "Patient-Doctor Relationships as Viewed by Psychiatry."

Dr. Alan Pasternack, Scientific Chairman, discussed the chiropodical products, "Zondex" and "Striated Elastoplast."

Dr. L. W. Marmon, Pharmaceutical Chairman, distributed clinical evaluating material provided by Burroughs, Wellcome and Company.

SOUTH CAROLINA

The annual business meeting of the South Carolina Chiropody Association was held in Columbia, S. C. The following were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—Walsh, W. R., U. S. Armed Forces M. J. 4:563, 1953.
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elected to office: President, Dr. James Hill; President-Elect, Dr. Bernard Silver; Vice-President, Dr. James Rice; Secretary-Treasurer, Dr. H. A. McAninch; State Board of Examiners, Dr. James Hill to replace Dr. Olin Bomar.

The motion was made, voted and passed, to change the name from South Carolina Chiropody Association to the South Carolina Podiatry Association.

TENNESSEE

At the last meeting of the Tennessee Chiropody Association held in Nashville, Tenn., February 1, 2, 1958, the following officers were elected: President, Dr. William J. Thomas of Memphis; Vice President, Dr. Richard Koch of Nashville; Secretary-Treasurer, Dr. Ronald Fields of Nashville; A.P.A. Delegate, Dr. William S. King of Memphis; Alternate Delegate, Dr. Ronald E. Fields of Nashville.

WASHINGTON

The Washington State Chiropody Association is playing host to the Region 7 Convention to be held in Tacoma, Washington, April 25, 26 and 27 at the Winthrop Hotel. John J. Bonica, M.D., who is an internationally known lecturer on all phases of anesthesiology and author of the classic textbook, "The Management of Pain" (reviewed in the N.A.C. Journal, page 582, Nov. 1957), will give an audio-visual presentation of the "Management of Pain in the Foot." Ernest E. Banfield, M.D., well-known plastic surgeon, who has worked with a number of local chiropodists, will show slides and lecture on "Reconstructive Soft Tissue Surgery About the Foot." Hans T. Frohlich, D.S.C., Clinical Director of the California College of Chiropody, is returning by popular demand and will lecture on "Current Trends in Podiatric Therapeutics" and "Interpretation of Laboratory Findings."

Activities are being planned for the ladies—golf for the men—dinner, dancing. For further information, write to E. J. Hannity, Pod.D., 611 2nd Street, N. W., Puyallup, Washington.

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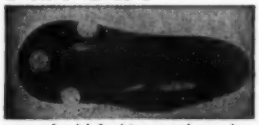

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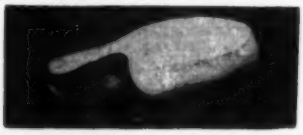

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CALIFORNIA COLLEGE SEMINAR TO COME EAST

The California College of Chiropody, for the first time is extending its 11th Annual Seminar to the Eastern part of the country for 1958. This Seminar was so well received in the four cities in the west that it was decided to repeat it and avail most A.P.A. members the opportunity to hear the world's renown Milton Erickson, M.D., Psychiatrist and lecturer on Hypnosis.

Dr. Erickson's lecture of two days prepares the chiropodists to use hypnosis in many everyday office problems with safety and ease. Interest has been so profound that study groups are forming in the cities Dr. Erickson has lectured. Dr. Erickson is known as the Dean of Hypnosis and lectures in 20 to 30 cities in the United States each year. He practices psychiatry in Phoenix, Arizona. Few articles are written in lay magazines or professional books or periodicals without reference to him.

Dates for Dr. Erickson's lectures are: Chicago, Ill., at Hotel Morrison, May 3, 4; New York City, June 7, 8; Philadelphia, Pa., June 14, 15. Advance registration fee, $35; fee at door, $50; American Podiatry Association members, Medical Doctors and Dentists only. An advance brochure with complete outline will be sent to members shortly. Chairman for the Seminar is Charles S. Ormond, D.S.C.

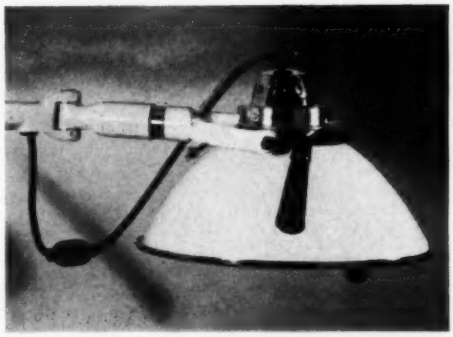
ALPHA GAMMA KAPPA

The National Convention of the Alpha Gamma Kappa Fraternity will be held in Cleveland, Ohio, March 14, 15, 1958. The National Executive Council of Alpha Gamma Kappa will meet at the same time. Host chapter is Kappa of the Ohio College of Chiropody.

2ND A.C.F.O. SCIENTIFIC SESSION

The 2nd Annual Scientific Session of the American College of Foot Orthopedists will be held in conjunction with the Midwest Chiropody Conference at the Morrison Hotel, Chicago, Thursday, March 20, 1958, from 1:30 to 9:00 p.m.

The subjects and speakers are: Ortho-



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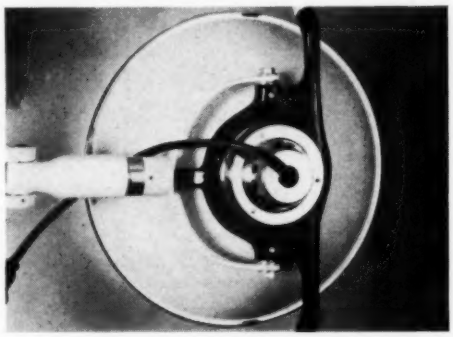
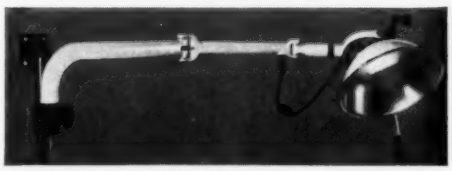


spin it around . . .



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DR. MUSSMAN HONORED

The VA Hospital at Montrose, New York, has conferred upon Martin Mussman, Pod.D., hospital podiatrist, its Superior Accomplishment Award, in recognition of an outstanding contribution to the operation of the hospital resulting from his superior performance.

Dr. Leon L. Rackow, hospital manager, conferred the honor on Dr. Mussman, presenting him with a cash award of $175.00 and a Certificate of Recognition. In making the presentation, Dr. Rackow added, "You possess those qualities of character, proficiency and skill demonstrated in the performance of your duties over and above the normal requirements of your position. This loyalty and devotion is not only an asset to you but I am sure it will serve as an example to your fellow employees."

Dr. Mussman, who has been with the hospital since December, 1950, has developed the podiatry program into a service of patient treatment, teaching, training and research. As part of the over-all clinic team, his service has made a contribution to the total patient care in his administrative and functional relationship with the other hospital services.

A native of New York City, he is a graduate of Emory University in Atlanta, Georgia, following which he attended the Long Island University College of Podiatry in New York City. Prior to his appointment at the VA Hospital, he served for a year at the Hospital for Joint Diseases in New York City.

DEAN KRAUSZ HONORED

The annual Founder's Day Symposium of the Temple University, School of Chiropody Alumni Association, was held January 26, 1958, at the Broadwood Hotel in Philadelphia. Dean Charles S. Krausz was honored at the testimonial luncheon in recognition of his many years of dedication to his profession and his school. As per the enclosed photograph, he was presented with a plaque by Dr. Frank Rubin (left), President of the alumni association, with Dr. Max Cohen (center), chairman of the affair, looking on. Dean Krausz also received a new desk from the Chiropody Society of Pennsylvania, a complete desk set from the student body and interior decoration to his office from his faculty.

Members of the class of 1933 were also honored at the luncheon on their silver anniversary and each member of the class present was presented with a certificate from the association.

Nearly 200 alumni from eastern United States attended the day of Science and Fellowship dedicated to the Founder of Temple University, Russell H. Conwell. An excellent scientific program was prepared and presented as part of the activities of the day.

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A.F.H.F. ANNOUNCES YOUTH FOOT CARE WEEK

For some time, the American Foot Health Foundation has been occupied with an extended study and research into the practices of various branches of the medical profession in conducting free children's examinations as a superior form of public education, stimulating interest among parents and children in good health practices. The Foundation's analysis incidently shows that such activities are of immeasurable value to the individual doctor and give evidence of his concern with the welfare of the public.

Since group foot examinations have been conducted in our profession somewhat sporadically, the A.F.H.F. is pleased to announce the establishment of "Youth Foot Care Week," based on an integrated, organized and tested program for conducting free foot examinations on a nationwide scale.

The method of procedure which the Foundation has developed is patterned on the idea successfully organized and executed by the New York Down State Divisions. This group, following conferences with the A.F.H.F., has recognized the great advantages which would accrue to the nation's foot health by nationalizing this highly efficient plan of operation and placing it in the hands of every foot doctor through the coordinating sponsorship of the Foundation. The eventual result of this plan is that it will make every youngster (and parent) cognizant of the importance of foot health and bring him in contact with the practitioner whose sole concern is his and the public's foot health.

Youth Foot Care Week is scheduled to be launched in October, 1958, and each year thereafter as an annual event. It will be springboarded through a nationwide educational campaign conducted by the Foundation. The briefing herein on how the program will operate and how the individual doctor can participate, will be enlarged in detailed outlines and sent to all state secretaries. Individual groups interested in conducting the program are also invited to write the Foundation for this material.

The Foundation will make available to state secretaries, regional and local groups and individual doctors all the materials and instructions required for efficiently conducting the children's foot examination phase of Youth Foot Care Week, as well as necessary administrative and educational material. As the mechanics of handling the examination are of primary importance for a successful operation, the Foundation's assistance in this connection will, among other matters, consist of:

1. How to organize administrative methods for appointment arrangements.

   a. Arrangements for place of examination, preferably a public place (school) or private office if necessary.

   b. The setup and operation of a cen-

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California College of Chiropody
1770 Eddy Street
San Francisco, Calif.

Chicago College of Chiropody
1422 W. Monroe Street
Chicago, Ill.

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
Chicago, Ill.

New York College of Podiatry
53 East 124th Street
New York, N. Y.

Ohio College of Chiropody
2057 Cornell Road
Cleveland, Ohio

Temple University, School of Chiropody
1810 Spring Garden Street
Philadelphia, Pa.

tral telephone answering station to receive and route calls for appointments for examinations and the establishment of a committee and chairman in charge.

c. Work procedures for assistance from the Women's Auxiliary.

d. Business reply cards, with cover letter to local chiropodists-podiatrists for indicating a yes or no interest in participating, and for recording the days and hours they will be reserving for children's foot examinations.

e. Forms of notifying doctors of appointments arranged by central telephone answering headquarters, requesting doctor concerned to phone parents if change in appointment is necessary. (This is a centralized control point freeing the doctor from calls to his office.)

f. Postcards for Central Youth Foot Care Week Committee to send to parent notifying of appointment with a specified doctor.

g. Foot examination charts for doctor to use in making examination, combining a detachable postcard for notifying parent of child examination findings. Also personal file card (detachable) for doctor's office record.

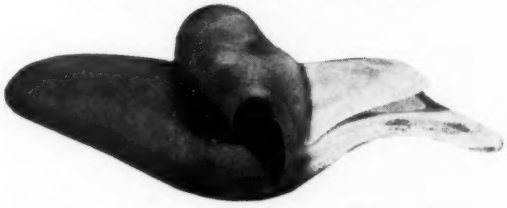
h. Suggested method for Central Committee to use in recording and analyzing the results of the examination program in terms of individual patient relations established, etc.

2. Promotional Material.

a. Cover letters to local public welfare and similar groups and individuals, i.e., educational, health, community civic, fraternal, mothers' clubs, P.T.A., Boy and Girl Scouts, etc.—with business reply card enclosed to be sent by group to local chairman of Youth Foot Care Week, requesting, (1) A representative to call to further discuss the program and (2) To arrange an appointment date for a lecturer and/or film on foot health.

b. Posters, etc. Also local news releases,

LIGHTWEIGHT!



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proclamation forms for Governors and Mayors, ways and means to secure cooperation and support of local groups, prepared talks for delivery locally, sources for slides and films, special material for dissemination to other branches of medical profession and related interests.

The deadline for completing arrangements for participation in Youth Foot Care Week and the Free Examination Program by state, regional and local groups and individual doctors has been set for June 30, 1958. The advance procedures necessary at the local level (and at the Foundation nationally) make it imperative that all who are interested in this project communicate immediately with the American Foot Health Foundation, 3301 16th St., N.W., Washington, D. C. Full details will be sent enabling doctors to prepare for action quickly in this program which is so vital to the Nation's Foot Health.

Sidney Hirschberg, Pod.D.
Forest Hills, N. Y.

DEATHS REPORTED

Dorothy M. Dean
Los Angeles, Calif.

Lowell W. Maneval
Green Bay, Wisc.

Irving W. Baumgaertner
St. Paul, Minn.

Dr. Baumgaertner passed away after an illness of several years. He practiced in St. Paul for almost forty-six years. During World War I he served in the Army Medical Corps as chiropodist with the Orthopedic Department.

Dr. Baumgaertner was very active in the Minnesota Association since its founding, serving in all offices of that Association. He also helped committee chairmanships of the National Association of Chiropodists. He became a Life Member in the National Association in 1953.

Dr. Baumgaertner is survived by a sister, a daughter and granddaughter.

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1958 HALL OF SCIENCE

Because the Hall of Science was such a big hit last year, we plan to repeat this interesting and informative section. The success of this phase of the convention depends entirely on the state societies, specialty organizations, schools and individuals who are represented by their exhibits. We are anxious to present an outstanding series of exhibits as they can produce nation-wide interest.

An exhibit contributes a great deal to the prestige of an organization which in turn reflects favorably on our profession.

To further increase the popularity and caliber of the scientific exhibits and encourage wider participation, awards of medals and citations will be given to outstanding exhibits. Awards will be made in the following categories:

1. Hospitals, Clinics, Colleges
2. Individual Practitioners
3. State Affiliated Societies
4. Allied Professions

We also anticipate and solicit exhibits from the following sources: Affiliated Scientific Organizations, Industrial Engineering Chemical Organizations, Pharmaceutical Houses Sponsors, Women's Auxiliary, The Colleges of Podiatry-Chiropody, The State Societies, The United States Army, Navy and Marines. Exhibits on insurance and legal and statistical phases of our profession are needed.

If you have an instrument, device or technic that you can mount and/or display adequately on a card or in a simple manner, please contact the committee in order that it can be exhibited in a "Gadgets and Gimmicks" section.

Illustrations of the gold, silver and bronze medals will be published in a subsequent issue of the Journal. Scientific exhibits may be of visual nature or a practical demonstration. This is your opportunity to present your research, experiments, demonstrations and/or other information to the profession.

For information and applications for scientific exhibits, write to Dr. Edward Ganny, Co-Chairman, Scientific Exhibits Committee, 1907 Eye Street, N.W., Washington 6, D. C.

HALL OF SCIENCE
1958

Individuals, State Societies and Organizations are being reminded that the 1958 Hall of Science will be an outstanding feature of our annual meeting in Washington, D. C., August 22-26, 1958. Now is the time to plan your exhibit as your contribution toward making this the greatest year ever. Don't delay — Start now!

CONTACT: *Committee on Scientific Exhibits*
Dr. Edward Ganny, Co-Chairman
1907 Eye Street, N. W.
Washington 6, D. C.

CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
Washington, D. C.
August 22-26, 1958
Shoreham Hotel

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Boston, Mass.
Oct. 17, 18, 19, 1958
Sheraton Plaza Hotel

Region Two
(New York)

Region Three
(Del., Md., N. J., Pa.)
Atlantic City, N. J.
April 17-20, 1958
Ambassador Hotel

Region Four
(Ohio)
Toledo, Ohio
May 17-18, 1958
Commodore Perry Hotel

Region Five
(Ill., Ind., Mich., Wis.)
Chicago, Ill.
March 21, 22, 23, 1958
Morrison Hotel

Region Six
(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Denver, Colorado
April 11-13, 1958
Cosmopolitan Hotel

Region Seven
(Idaho, Mont., Oreg., Wash., Wyo.)
Tacoma, Wash.
April 25, 26, 27, 1958
Hotel Winthrop

Region Eight
(D. C., N. C., S. C., Va., W. Va.)

Region Nine
(Florida)

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Dallas, Tex.
June 19-22, 1958
Statler Hilton Hotel

Region Twelve
(Ariz., Cal., Nev., Utah)
Los Angeles, Calif.
May 30-31, 1958
Ambassador Hotel

Alpha Gamma Kappa Fraternity
Cleveland, Ohio
March 14-15, 1958
Ohio College of Chiropody

Little Johnny, son of the minister, was sitting on the front porch when a member of the church passed by. "I hear your Daddy has received a call to a church in another city at a larger salary," she said. "Is he going to take it?"

"Don't know," replied Johnny. "Daddy, he's in his study praying about it, but Mom's upstairs packing."

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Valuable prizes for winners and souvenir awards to all contestants.

"Region 3 Handicap Golf Tournament"

"Annual Region 3 Open House Party" —
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President's Dinner Dance honoring our national president and former General Chairman of Region 3 Conventions
Dr. Jonas C. Morris.

First Annual Presentation of Speidel Merit Award Plaque

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Thursday, April 17 — A Guided Tour of interest

Friday, April 18, 12:30 P.M. Luncheon
Guest — Anita Priest — "Look Homeward, Madam . . ."

Saturday, April 19, 11:30 A.M. — Brunch
Guest — Mr. Fred Rogers — "Trust & The Wife" . . .

Registration $10.00 Mail check or money order to

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COMMUNICATIONS FROM THE PROFESSION

To the Editor:

The following news article reported locally the objectives outlined by Manford C. Bear, president-elect of the Wisconsin Association of Real Estate Brokers, at their state meeting two weeks ago In reading this article, each successive paragraph carried home the thought that this was written specifically for us.

With a deletion of only one sentence, and one phrase, and substituting the underlined words for the originals which are in parentheses, I offer the following:

"He said the state group should divide its time between . . . education and legislative matters, with major emphasis on the former.

"Fifty years ago podiatry-chiropody (real estate) was not a profession (business) that a young man could enter with any assurance of prestige or profit. In those days the podiatrist-chiropodist (broker) was usually only a peddler . . . with little or no special training for the job, and was often regarded with suspicion by the general public.

But, he continued, "We have come a long way in the past fifty years. . . . Consequently Mr. Public is quite willing to pay a reasonable fee to the doctor (broker) who knows how . . . and who can protect his interests.

For the first time in a number of years we are entering the New Year with a doubtful economic situation. It appears the gravy train is slowing down a bit.

It is becoming more and more apparent that the podiatrist-chiropodist (broker) who does not keep abreast of the newest and most up-to-date methods, will fall by the wayside. Consequently, education is of the utmost importance.

On the legislative side, we must bear in mind that we are . . . a professional (trade) organization, and that we must unite our men for the purpose of exerting a combined

THE REGIONAL CONVENTION COMMITTEE OF IDAHO, MONTANA, OREGON, WASHINGTON, WYOMING, AND BRITISH COLUMBIA

cordially invites your attendance

at the

1958 Region 7 Chiropody Convention
to be held in Tacoma, Washington
April 25, 26 & 27 — Hotel Winthrop

OUTSTANDING SPEAKERS INCLUDE:

John J. Bonica, M.D., D.A.B.A., F.A.C.A., F.I.C.A.
Internationally known lecturer and Author of the classic textbook "The Management of Pain."

Subject:
Management of Pain in the Foot and Leg.

Ernest E. Banfield, M.D., F.A.C.S.
Faculty member, University of Washington Medical School.

Subject:
Soft tissue tumors about the foot.

Hans T. Frohlich, D.S.C.,
Clinical Director of the California College of Chiropody.

Subjects:
Current trends in Podiatric Therapeutics—Interpretation of Laboratory Findings.

For further information write to: **E. J. Hannity, Pod.D.**
611 2nd Street, N.W., Puyallup, Washington

influence upon matters of podiatric-chiropodal (real estate) interests.

As government has moved more directly into every phase of business activity, it has become as essential for professional (business) groups to have lobbying representation in legislative chambers as to be represented by an attorney at court.

It is unfortunate that some men are opposed to local societies (boards) and the state organization, but it is not difficult to find the cause of this attitude. Since democracy is basically a counting of noses, the strongest lobby usually is the one controlling the largest number of votes—and being a relatively small group . . . podiatry-chiropody (realtors) on occasion have been subjected to the 'scapegoat treatment.'"

To me, this could have been rendered by any state or national officer in his inaugural address. This was written for podiatry-chiropody!

Howard R. Reinherz, D.S.C.
Kenosha, Wisc.

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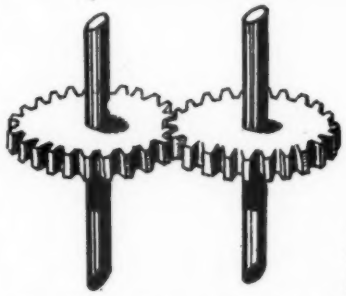

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To the Editor:

The stepped-up program of the A.P.A. is a thing of beauty to behold. And I take great pride in being able to play a role in the forward march towards more and more recognition. I must say that in 18 years of practice and affiliation with the profession, more is being done actively now than ever before. My wholehearted efforts will be placed at your disposal whenever and wherever you can use my abilities.

All fields of endeavor apparently are being explored. This is to your credit as a great organizer and guiding spirit. I must, too, compliment the various committees and their counterparts for the momentous drive that is evidenced in their forward policies.

Kindly extend my heartfelt wishes for a continuance of these efforts to all concerned. And many, many thanks to you and your greatly overworked staff of zealots.

Dr. T. W. Cockrell
Minot, N. Dak.

To the Editor:

In the December issue of the Journal of the National Association of Chiropodists (A.P.A.), I noted in the section of Letters to the Editor, a suggestion for the change of our degree D.S.C. for one more accommodating to our "neocognomen" as podiatrists.

My intention in this correspondence is merely to accord my wholehearted enthusiasm. I believe that not only will a degree of M.D.P. or D.M.P. be more consistent with our national title of A.P.A., but will undoubtedly be another factor to aid in the elevation of our professional prestige.

The psychology of patient-podiatrist relations is dependent on a multi-minutiae basis from such nonentities as to one's physical carriage to one's professional demeanor.

At present the public at large is familiar only with two degrees—one primarily is the M.D., the other, slightly less so, the D.D.S. or D.M.D. It is necessary for us to facilitate as easily as possible the matter of public comprehesion in as many details as possi-

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ble pertaining to their foot doctors.

To be most candid, it behooves us to capitalize on a pre-existing and well-acquainted fact. This, I believe, will be another giant step in the direction of progress and apparently at present, our A.P.A. knows of no other direction.

In all probability this transition will ensue from your (A.P.A.) recommendation to the Schools of Chiropody throughout the country—this, however, being merely a factor of my opinion. At any rate, may I take this opportunity to commend all the officers of the A.P.A. on their most prodigious accomplishments.

Michael Romano, D.S.C.
Barrington, R. I.

To the Editor:

Before and since I became a member of the profession of which I am very proud, the constant cry has been "More and Better Public Relations!" Educate the Public Chiropodically! But alas! Too much "apathy." Our national and local organizations did very little about it and as a result our schools have suffered desperately and the progress of our profession more so.

Now that we are beginning to see a ray of light for chiropody, our "apathy" prevails again when the delegates at the last national convention pull a fast one and change our professional designation to podiatry. Through the years we have been slowly and gradually educating the "public" to the correct pronunciation and terminology of chiropody and what we can do for a nation of aching feet. But the "public" be damned. We now must start from scratch and re-educate them on why the change and how to pronounce "podiatry." I can hear the ridicule from the public and allied professions. In my thirty-five years of practice, I have heard as many mispronunciations and interpretations of podiatry as I have of chiropody despite the fact that the American Podiatry Association says the name change is for the public to find it easier to use.

I wonder how many of the men who

voted for this change would like their name changed because someone didn't like it. Through the years, I have traveled extensively in the United States and Canada and the consensus of opinions of chiropodists is for chiropody.

I question the intelligence of the delegates from the chiropody states to have permitted such a deplorable fiasco. But again, "the apathy of the profession." Many, as individuals, are doing a lot of complaining about it but doing nothing collectively.

A few years ago, the delegates voted an ultimatum date for the podiatry states to change to chiropody. It was obvious that they were not going to change over and again the apathy of the N.A.C. did nothing about enforcing the edict. The podiatry states now feel victorious and perhaps chiropody will go into oblivion. Or are we going on into the future indefinitely with a dual terminology as in the past, immature, without firm and positive thinking? And an attitude of apathy from the profession?

We have arrived at the level of success and progress that we now enjoy because of a few energetic state societies and a small band of chiropody-conscious men, the stalwarts of our profession, rather than the egotists who climb the ladder of ambition for their own aggrandizement. Otherwise we have remained immature and very definitely a minority group, anxious to grow up, but too much "apathy of the profession" towards success, progress and public relations.

Chiropodists! Awake from your lethargy and express yourselves! We could be as powerfully strong as our major allied professions if we would exert our energies in the right channels for CHIROPODY!

Joseph J. Jacobs, D.S.C.
Detroit, Mich.

One reason that children brighten up a home is that they never turn out the lights.

An auction sale is a sale where you get something for nodding.

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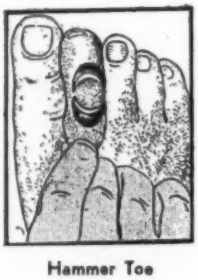

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A.O.P.

BOBBY had snitched Jimmie's apple in school and the teacher had caught him. "Don't you know that you have broken the Eighth Commandment?" she sternly asked.

"Yes'm," admitted Bobby, "but I might as well break the Eighth and have the apple as break the Tenth and only covet it."

"But Madam," insisted the salesman, "you can save enough on your food bills to pay for this freezer."

"Oh yes, I know," agreed the woman wearily, "but we are paying for our car on the carfare we save and we're paying for our washing machine on the laundry bills we save and we're paying on our home with the rent we save and we just can't afford to save any more money just now."

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Rotary Bulletin, Stratford, Canada

There was a time when a fool and his money were soon parted, but now it happens to everybody.

The Pilot, Galveston, Texas

"He's got the stuff," it's clear enough,
But most folks will assert
That he has got the kind of stuff
That goes to stuff a shirt.

Berton Braley

He was a very old man—102 in fact. "No sir," he replied in answer to a question. "I never used glasses. Just drank it right out of the bottle."

Patience is the ability to idle your motor when you feel like stripping your gears.

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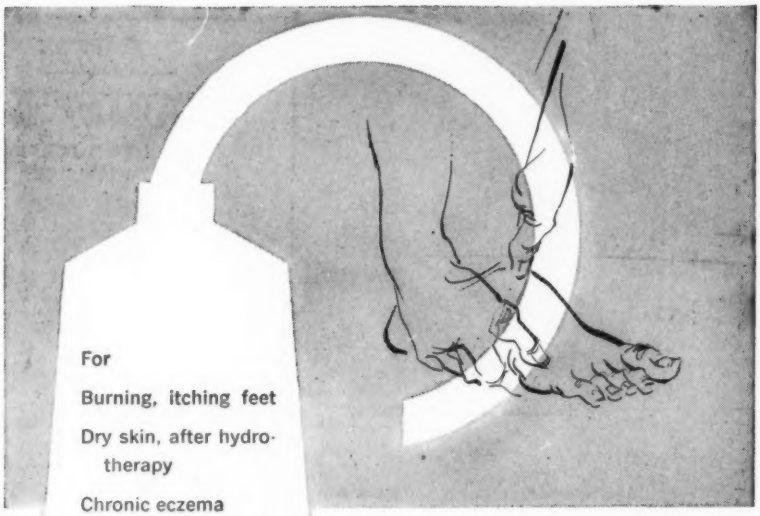

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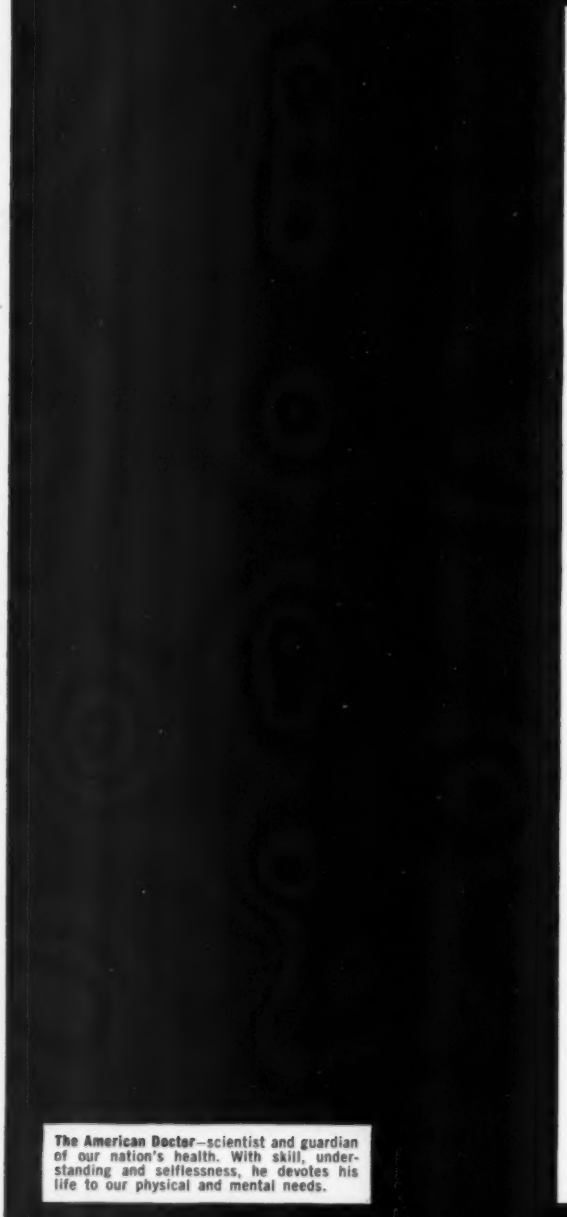

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